2009

Annual Hospitals Report

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ACRONYMS

AOA	American Osteopathic Association
BHCQC	Bureau of Health Care Quality and Compliance
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare and Medicaid Services
DNV	Det Norske Veritas
HAC	hospital-acquired condition
HAI	healthcare-associated infection
TJC	The Joint Commission
NAC	Nevada Administrative Code
NHSN	National Healthcare Safety Network
NRS	Nevada Revised Statutes
NSHD	Nevada State Health Division

INTRODUCTION

This first annual report provides information concerning the regulation of hospitals in Nevada. The intent is two-fold: first, to provide insight on any systemic issues that may be affecting facilities of this type, and second, to identify areas for each facility where improvements with the most immediate impact can be made, either by the facilities themselves or in collaboration with NSHD. The report is a work-in-progress, meaning that future editions of the report will reflect improvements and innovations in measuring quality of care. These supplemental response documents will contain tangible and measurable actions representing improvements that will have been made at various hospitals in Nevada to elevate the quality of care provided.

The data provided in this report is based on calendar year 2009. The report begins with an overview of hospitals followed by individual profiles for each. The individual profiles are presented to inform both the public and each hospital of the findings for each and are followed by responses to the findings from the hospitals themselves or the organizations that govern them. The reader should use caution if attempting to compare facilities as the comparability is limited on account of differences in patient populations, geographic location, and facility resources. A considerable effort has been made to ensure the accuracy of the data contained in the profiles.

It is the sincere hope of the Health Division that through regular public reporting and collaboration with facilities we can identify and jointly address the issues that impact the quality of care provided at healthcare facilities in Nevada. The Health Division encourages healthcare facilities to strive to provide the highest level of care possible, and to seek the assistance of the division to meet our common goals.

EXECUTIVE SUMMARY

Nevada and the nation have struggled with problems of quality in hospitals and healthcare. In 1999, the Institutes of Medicine identified and described many of these problems in the landmark publication *To Err Is Human: Building a Safer Health System*. The data contained in this report indicates that much work still remains over a decade removed from that historic publication. Unfortunately, the healthcare landscape has become more complex since 1999 and to affect real change a cultural shift must be pursued by medical professionals, their representative organizations, corporate interests, employee representatives, policy-makers, and governmental oversight agencies. It will take an enormous effort by all sectors to change from a system of blame, avoidance of blame, denial, and a history of non-public disclosure. As difficult as these endeavors are, there are those in Nevada from the media, public and private sectors stepping forward to affect the change that is needed. This report is intended to further the discourse and continue to seek improvements to provide every person who receives healthcare in Nevada the best quality and assured safety.

This report begins with a general overview of Nevada hospitals, followed by individual profiles for each. It displays and describes tables, charts, and data gathered by BHCQC regarding findings from facility inspections, complaint investigations, sentinel events, focused infection risk assessment surveys, and HAIs for each of Nevada's 60 urban and rural hospitals. This first report provides a baseline and an overview of the most recent complete year of data on potential risks associated with healthcare, adverse events, and medical errors. Additionally, it explores the best approaches for preventing them, with a focus on the most common types of events such as HAIs, falls, and retained foreign objects and other preventable events. Public reporting is one of several important tools for ensuring accountability. This baseline report describes frequencies and rates for each of these categories and events. It describes potential underlying causes and explores reasons for why such events continue to occur. Additionally, it sets the stage for focused and proper interventions to prevent them from happening again, in order to create the safest possible healthcare system.

HAIs represent a major threat to patient safety, healthcare quality, and the entire public health system. The medical, financial, and societal burden of HAIs has a significant impact upon healthcare cost containment, as well as on patient care outcomes, and the quality of life in our state. However, it is important to point out that the collection and reporting of HAI data is still evolving, and there is little, if any, comparative information by which trends in healthcare quality and HAIs can be evaluated.

This publication is just a start toward more careful monitoring, tracking, and evaluation of healthcare systems. It can be useful for healthcare consumers and policy-makers in evaluating the quality of care, and for hospital administrators and clinicians who are striving to improve the quality of care delivered to their patients. It can also help initiate productive discussions between patients and healthcare providers, and can serve as a tool for the healthcare system regarding the need to reduce medical errors, eliminate infections, and improve healthcare quality in general. Armed with that information, patients and family members can ask providers what is being done in their facility to prevent such events from occurring.

In order to improve the safety in healthcare settings, hospitals and other healthcare facilities can use this report to identify situations of concern and develop safe and high-quality healthcare. The primary purpose of this report is to ensure that up-to-date statewide hospital data and clinical outcomes are made available to the general public in a clear and usable format. The goal of developing this report is to establish a deeper understanding of why deficiencies and adverse health events continue to happen, so that strategies can be developed to prevent future medical errors and

prevent future patients' harm. Additionally, one of the goals in developing this report is to promote a culture of safety, accountability, and transparency so that healthcare providers can identify errors and strive to prevent them.

Information in this report should be perceived as the basis for further learning, not simply a way to compare facilities based on numbers and rates. Patient awareness is a very important tool to improve safety, but it is important to keep these figures in perspective. The intention of this report is to identify shortfalls and errors, and it is worth noting that healthcare quality in hospitals is more than just the sum of the particular measures presented in this report. Nevada hospitals provide safe and successful healthcare services for large numbers of other illnesses and conditions not addressed in this report.

The information provided here can assist policy-makers, the public, healthcare providers, hospital staff, and administrators to take appropriate and timely measures to reverse the alarming trends in adverse events. It is our expectation that over time, both the frequency and severity of healthcare adverse events will decrease, as appropriate and timely interventions are gradually implemented and regulations are seriously enforced to reduce the likelihood of such errors.

NSHD has presented this report to every hospital and solicited a response to the report's findings from each. NSHD asked the hospitals to formulate measurable outcomes to be implemented over both the short- and long-term in a manner fully transparent to the public. The hope is that by executing these plans and responding to the feedback of the data, Nevada can achieve a level of healthcare comparable to, if not better than, that which exists elsewhere in the country. Nevadans deserve nothing less.

HIGHLIGHTS OF THE REPORT

Over the past year NSHD has identified and collected detailed information on just over 500 deficiencies that occurred in urban and rural hospitals. More than 91% of urban and 53.3% of rural hospitals had complaints filed against them in 2009. However, about two thirds of these complaints were either unsubstantiated or no action was taken or necessary to remediate the problem. Among all deficiencies *life safety code standard* was cited most frequently, and *appropriate care for patient* was the most widely spread deficiency encountered in 17 urban and 3 rural hospitals. More than a half of the complaints (57.1%) related to urban hospitals. At rural hospitals, about 40% of complaints were filed by patients or their families; telephone was the most frequently used method to file these complaints.

About 82.4% (201) of all sentinel events in Nevada during 2009 were reported by hospitals, while less than 18% were reported by other medical facilities. Similar to observed trends in other states, HAIs accounted for most of the reported sentinel events, representing about 26%, and falls ranked second with about 17.4%. It is important to emphasize that more than 46% of all reported sentinel events posed a risk of physical injury to patients and about 28% (56) of those involved with a sentinel event died as a result.

The Health Division requires that all reporting facilities complete a root cause analysis to determine the exact circumstances around the sentinel event, a description of what happened and how to prevent recurrences. It would be very difficult to prevent serious future events without uncovering the root causes of such preventable infections or injuries. Thorough investigation of sentinel events and detailed analysis for the patterns observed could be very helpful for healthcare facilities and medical/administrative staff to identify subtle underlying causes, vulnerability in the care process, miscommunication, or other discrete problems in the hospital policies and procedures. Additionally, such analyses can be used to identify strategies for improving the overall processes of care, with the ultimate goal of preventing avoidable harm to patients.

HOW TO USE THIS REPORT

Because the facility inspection and hospital survey process are technical in nature, the interpretation of the results described in the report may pose some challenges. In an effort to make this report easier to understand, the Facility Inspections, Severity and Scope Criteria for Evaluation document is included in Appendix A.

This report is one of several sources of information now available from BHCQC. It is designed to help patients identify issues of concern to discuss with their care providers and to give policy-makers an overview of activities and services implemented to ensure patient safety. However, it is only one piece of the larger picture of patient safety and healthcare quality. Events listed in this report represent a very small fraction of all procedures and admissions at the Nevada hospitals, and it is essential to emphasize that not all of these events are easily preventable.

Measuring healthcare quality is a complex task, and the information used to capture such measures is limited. This is the first hospital-specific report for Nevada in which data and information is available for the entire year of 2009. It is intended to be used as a baseline to measure individual hospital performance over time, rather than to compare hospitals to each other. It can also be used as a tool to help public health leaders to ask physicians and hospital representatives informed questions, especially about infection control and prevention. However, it is not intended to be the sole source of information in making decisions about hospital care, nor should it be used to generalize about the overall quality of care in Nevada hospitals.

Reported frequencies could be higher or lower at a specific facility for a variety of reasons. A higher number of reported events does not necessarily mean that a facility is less safe, and a lower number does not necessarily mean the facility is more safe. In some cases, the number of events may be higher at facilities that are especially vigilant about identifying and reporting errors. Furthermore, the reporting system itself may have an impact by fostering a culture in which staff feels more comfortable reporting potentially unsafe situations without concerns about repercussions. It is important to note that in some cases, higher numbers may represent a positive outlook towards greater attention to adverse events and their causes, rather than the opposite. Additionally, larger referral hospitals may naturally experience higher rates of patients with negative health outcomes.

It is important to emphasize that all such events should provide opportunity for learning and for system improvement. No one tool or document can adequately assess the appropriateness of a hospital for a particular patient. The information provided in this report cannot substitute for a thorough review and evaluation of the specific hospital performance as it related to each individual patient. Consumers should always discuss the selection of a hospital with their personal physician, and should also contact administrators and staff for each hospital they are considering in order to discuss facilities, performance, and service availability at that hospital. Additionally, it is recommended that consumers spend some time talking with medical professionals, family, friends, and consumer organizations about specific hospitals they are planning to use to in order to evaluate services, safety, and care quality.

OVERVIEW

Licensure and Certification

Authority

Under the authority of the State Board of Health and the State Health Officer, pursuant to NRS 439 and 449, BHCQC is responsible for the licensure and certification of healthcare facilities and medical laboratories in Nevada. The mission of the bureau is:

> To protect the safety and welfare of the public by promoting and advocating quality healthcare through licensure, regulation, enforcement, and education.

Licensure

Statutory and regulatory licensure requirements for health facilities exist at the state level. With the exception of a few facility types, a state license is required by NSHD before any healthcare facility may begin providing services. To continue operating, a facility must annually renew its license by December 31st of each year.

Certification

Although not required to operate, a healthcare facility may seek certification from CMS to qualify for reimbursements through Medicare and/or Medicaid. However, since initial certification is a low priority for CMS, facilities often opt for deemed status from an approved accrediting organization. Deemed status simply means that the facility has met the accrediting body's standards which are deemed acceptable in lieu of certification.

Nearly all hospitals in Nevada are accredited by a nationally-recognized accrediting body. Accrediting organizations include the American Osteopathic Association's Healthcare Facilities Accreditation Program, Det Norske Veritas, and The Joint Commission. TJC was the primary provider of accreditation in 2009.

State agencies throughout the United States have federal-state agreements to serve as the field agent for CMS. NSHD has such an agreement and has further delegated the responsibility of conducting the federal certification inspections to its Health Facilities section, at the request of those wishing to receive reimbursement for providing medical services to Medicare and/or Medicaid enrollees. In addition to ensuring compliance with federal regulations related to quality of care, inspectors review life safety code requirements at the facilities to ensure they are in compliance with federal regulations.

ASPEN

ASPEN is a suite of software applications designed for the federal government by Alpine Technologies. It is used to collect, track, and manage healthcare provider data. The federal government has contracted with state governments, including Nevada, to have state personnel, usually through a state agency, conduct federal surveys/inspections and respond to complaints. All inspections are recorded in ASPEN Central Office, a component of the ASPEN suite. All complaints are recorded in ASPEN Complaint and Incident Tracking System, another component of ASPEN.

Inspections

Inspections conducted by BHCQC includes 5 essential activities:

1. Pre-inspection information gathering and facility file review
2. On- and/or off-site information gathering and compliance determinations
3. Notifications to other entities when public health issues are identified
4. Citation of non-compliance and plans of correction when necessary
5. Application of sanctions when necessary

For a detailed overview of the inspections process, regulatory sanctioning, and the severity and scope system, see Appendix A.

In 2009, 97.7% of urban hospitals were inspected as a result of 210 inspections. No inspection was conducted at the following hospital:

- Lake's Crossing Center

In 2009, 66.6% of rural hospitals were inspected as a result of 21 inspections. No inspections[1] were performed at the following rural hospitals:

- Battle Mountain General Hospital
- Humboldt General Hospital
- Nye Regional Medical Center
- South Lyon Medical Center
- William Bee Ririe Hospital

As a result of the inspection process, deficiencies related to state and/or federal regulations are cited and issued to facilities in the form of an inspection report known as a statement of deficiencies. Where necessary, a plan of correction is required of facilities in order to maintain licensure compliance.

In total, 505 deficiencies were cited in 2009, 441 among urban hospitals and 64 among rural hospitals.

On the following pages, Figure 1, Figure 2, and Figure 3 show the frequency of each deficiency cited against all hospitals, urban hospitals, and rural hospitals. Figure 1 is limited to those deficiencies cited more than 4 times, Figure 2 those cited more than 3 times, and Figure 3 those cited more than 2 times. For further information on the federal or state regulation associated with each deficiency tag, follow the links provided in Appendix B

[1] as based on the date the survey began

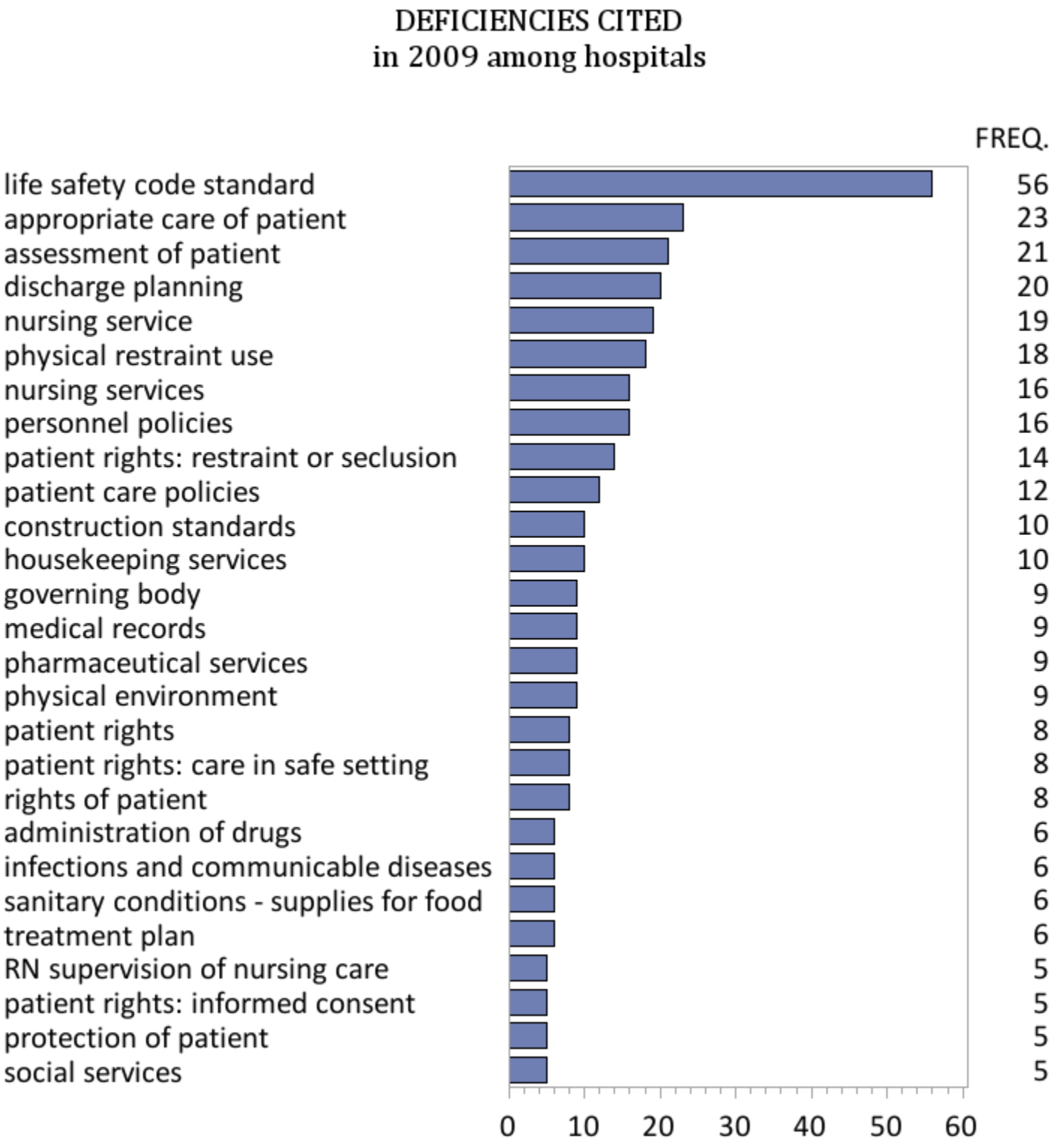
DEFICIENCIES CITED
in 2009 among hospitals
FREQ.
life safety code standard 56
appropriate care of patient 23
assessment of patient 21
discharge planning 20
nursing service 19
physical restraint use 18
nursing services 16
personnel policies 16
patient rights: restraint or seclusion 14
patient care policies 12
construction standards 10
housekeeping services 10
governing body 9
medical records 9
pharmaceutical services 9
physical environment 9
patient rights 8
patient rights: care in safe setting 8
rights of patient 8
administration of drugs 6
infections and communicable diseases 6
sanitary conditions - supplies for food 6
treatment plan 6
RN supervision of nursing care 5
patient rights: informed consent 5
protection of patient 5
social services 5
0 10 20 30 40 50 60

Figure 1


DEFICIENCIES CITED
in 2009 among urban hospitals
title
FREQ.
life safety code standard 56
appropriate care of patient 23
assessment of patient 21
discharge planning 20
nursing service 19
physical restraint use 18
personnel policies 16
patient rights: restraint or seclusion 14
construction standards 10
housekeeping services 10
governing body 9
medical records 9
nursing services 9
pharmaceutical services 9
physical environment 9
patient rights 8
patient rights: care in safe setting 8
rights of patient 8
administration of drugs 6
infections and communicable diseases 6
sanitary conditions - supplies for food 6
treatment plan 6
RN supervision of nursing care 5
patient rights: informed consent 5
protection of patient 5
infection control officer responsibilities 4
protection of patients 4
social services 4
use of restraint or seclusion 4
0 10 20 30 40 50 60
FREQUENCY

Figure 2

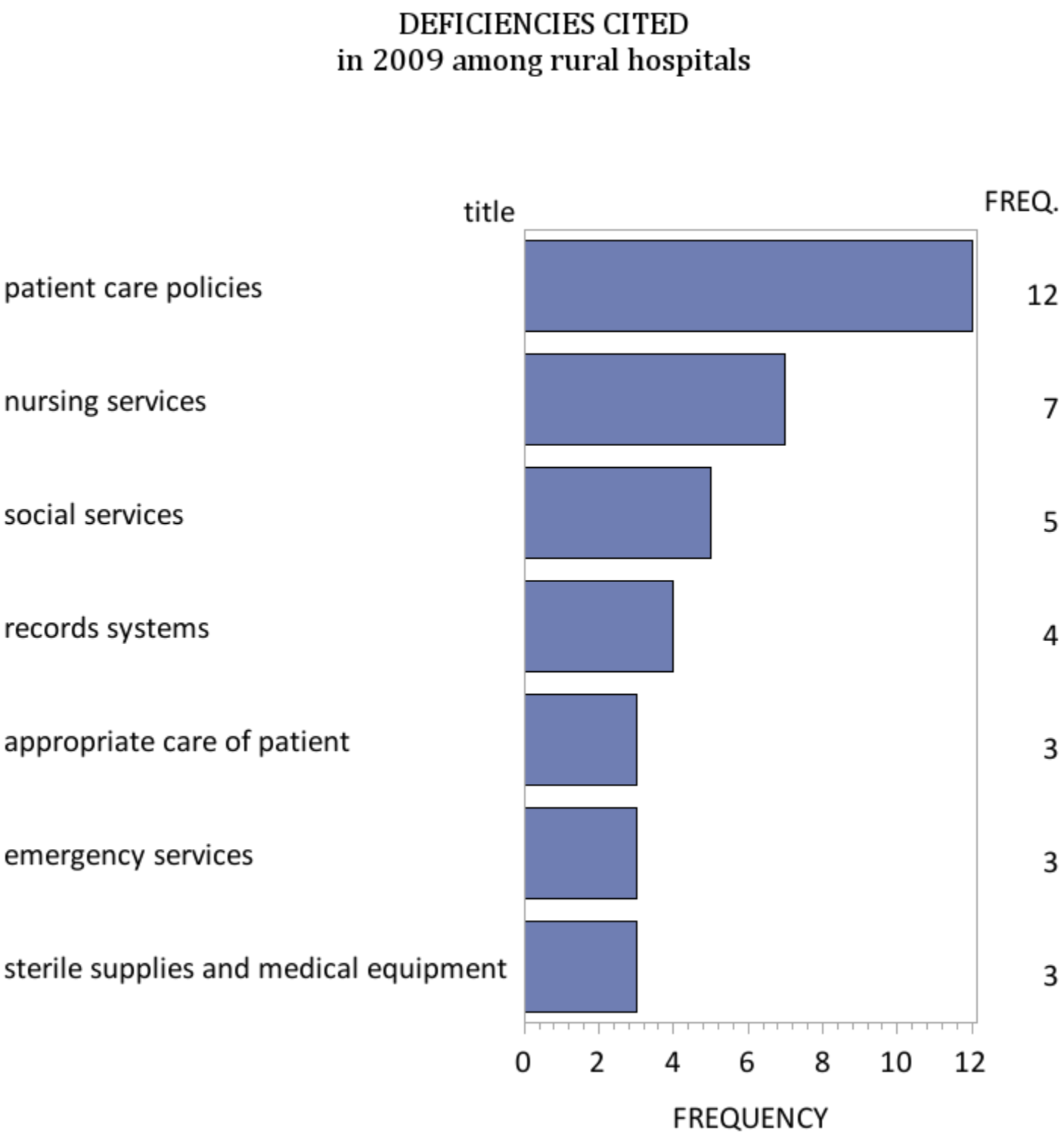
DEFICIENCIES CITED
in 2009 among rural hospitals
title
FREQ.
patient care policies
12
nursing services
7
social services
5
records systems
4
appropriate care of patient
3
emergency services
3
sterile supplies and medical equipment
3
0
2
4
6
8
10
12
FREQUENCY

Figure 3

Among all hospitals, deficiencies related to *life safety code standard* were cited most frequently. *Appropriate care of patient* and *assessment of patient* were next, followed closely by *discharge planning*, *nursing services*, and *physical restraint use* deficiencies.

Among urban hospitals, the most frequently cited deficiency was related to *life safety code standard*. The second and third most frequently cited deficiencies were related to *appropriate care of patient* and *assessment of patient*.

Among rural hospitals, the most frequently cited deficiency was related to *patient care policies*. The second and third most frequently cited deficiencies were related to *nursing services* and *social services*.

Beyond the absolute frequency of the citations is how widespread the deficiencies are across each facility type. Among urban hospitals, the following 3 deficiencies were the most widespread (more than 3 are listed due to equivalent proportions):

- appropriate care of patient (37.8%)
- assessment of patient (28.9%)
- nursing service (28.9%)
- personnel policies (28.9%)
- discharge planning (24.4%)

Among rural hospitals, the following 3 deficiencies, including ties, were the most widespread:

- nursing services (26.7%)
- appropriate care of patient (20.0%)
- records systems (20.0%)
- sterile supplies and medical equipment (20.0%)
- dietary services (13.3%)
- patient care policies (13.3%)
- social services (13.3%)

Table 1 and Table 2 on the following pages show the top 21 deficiencies in terms of their scope among each facility type.

SCOPE OF DEFICIENCIES CITED
in 2009 among urban hospitals

how to read this table:

This table shows the scope of deficiencies cited against urban hospitals, including the title, the total number of facilities cited for each, and the percentage of facilities cited.

MOST WIDE-SPREAD DEFICIENCIES (January 1, 2009 – December 31, 2009)		
title	**# of facilities cited**	**% of facilities cited**
appropriate care of patient	17	37.8%
assessment of patient	13	28.9%
nursing service	13	28.9%
personnel policies	13	28.9%
discharge planning	11	24.4%
construction standards	7	15.6%
pharmaceutical services	7	15.6%
physical restraint use	7	15.6%
infections and communicable disease	6	13.3%
medical records	6	13.3%
nursing service	6	13.3%
administration of drugs	5	11.1%
housekeeping services	5	11.1%
life safety code standard	5	11.1%
patient rights	5	11.1%
rights of patient	5	11.1%
governing body	4	8.9%
patient rights: care in safe setting	4	8.9%
physical environment	4	8.9%
protection of patients	4	8.9%
adequate respiratory care staffing	3	6.7%

Table 1

SCOPE OF DEFICIENCIES CITED
in 2009 among rural hospitals

how to read this table:

This table shows the scope of deficiencies cited against rural hospitals, including the title, the total number of facilities cited for each, and the percentage of facilities cited.

MOST WIDE-SPREAD DEFICIENCIES (January 1, 2009 – December 31, 2009)		
title	**# of facilities cited**	**% of facilities cited**
nursing services	4	26.7%
appropriate care of patient	3	20.0%
record systems	3	20.0%
sterile supplies and medical equipment	3	20.0%
dietary services	2	13.3%
patient care policies	2	13.3%
social services	2	13.3%
assessment of patients	1	6.7%
construction standards	1	6.7%
delivery rooms	1	6.7%
direct services	1	6.7%
discharging planning	1	6.7%
emergency services	1	6.7%
final observation	1	6.7%
infections and communicable diseases	1	6.7%
intensive care services	1	6.7%
maintenance	1	6.7%
medication orders	1	6.7%
nursing service	1	6.7%
obstetrical services	1	6.7%
outpatient services	1	6.7%

Table 2

Complaint Investigations

When NSHD receives a complaint, the first task is to assign it a priority. To determine the priority of investigation for each complaint received, complaints are triaged according to the recommended system outlined in Table 3 and Table 4 below.

COMPLAINT PRIORITIES

how to read this table:

This table shows the time allowed from receipt to investigation for complaints involving state licensure issues based on the priority of the complaint.

STATE COMPLAINT PRIORITIES	
priority	**time from receipt to investigation**
unlicensed residential facilities for groups	72 hours
other unlicensed facilities	dependent on established priority

Table 3

how to read this table:

This table shows the time allowed from receipt to investigation for complaints involving federal certification issues based on the priority of the complaint.

FEDERAL COMPLAINT PRIORITIES	
priority	**time from receipt to investigation**
immediate jeopardy (IJ)	2 working days
hospital validation complaint	5 working days
Emergency Medical and Treatment and Active Labor Act (EMTALA)	5 working days following CMS authorization
restraint seclusion death reports	5 working days following CMS authorization
non-IJ high	10 working days
non-IJ medium	45 working days

Table 4

Figure 4 and Figure 5 below show how complaints were prioritized for urban and rural hospitals. For both, non-IJ medium complaints were the most common, although the share was greater among urban hospitals, 55.0% versus 44.4%. Non-IJ high was the second most common priority for urban hospitals at 14.8%, and non-IJ admin review/off-site investigation was the second most common priority for rural hospitals at 16.7%. Non-IJ low and referral were next among urban hospitals at 11.8% and 6.8%, and as for rural hospitals, no action necessary and non-IJ high were next, both at 11.1%. No IJ complaints were received in 2009.

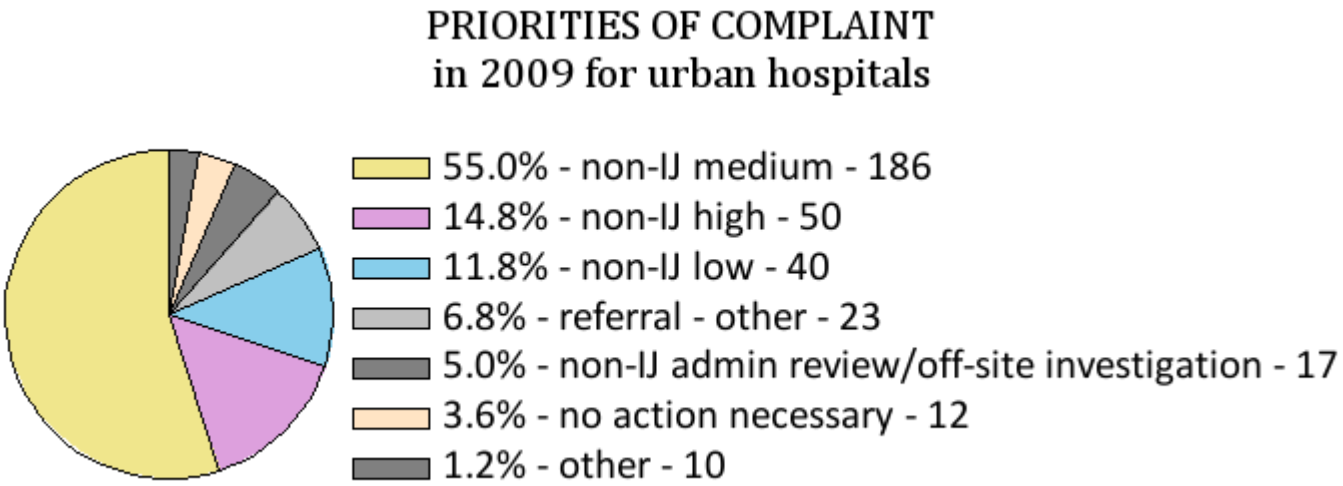

Figure 4

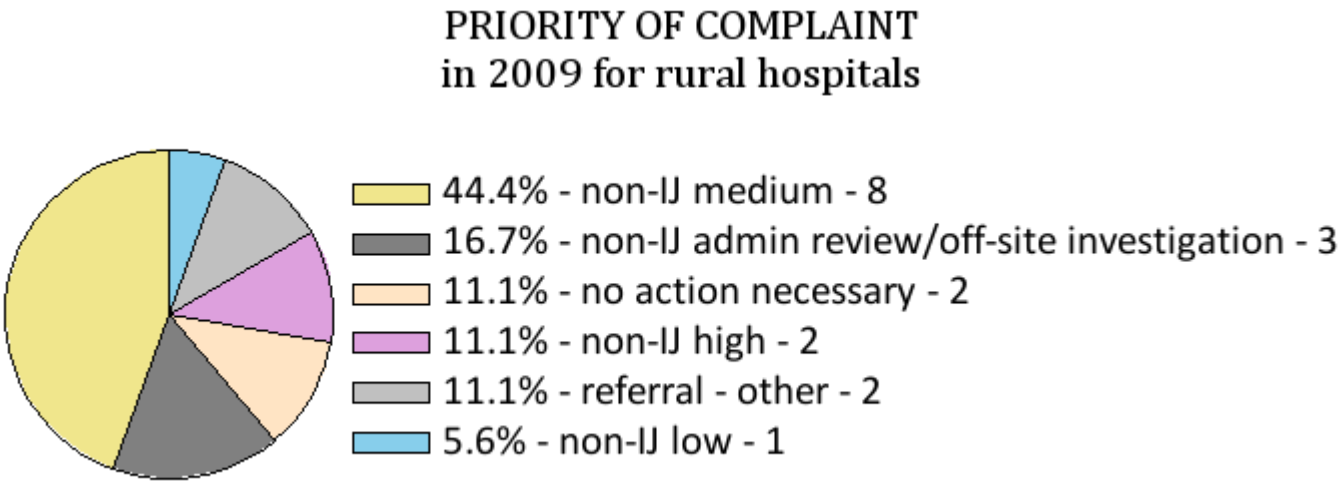

Figure 5

Figure 6 and Figure 7 below represent the sources of complaint for urban and rural hospitals. For urban hospitals, the major source of complaints was resident/patient/client, 29.6%; while it was other state agency for rural hospitals at 33.3%. For urban hospitals, family was the second most common source of complaint at 27.5%, for rural hospitals, the second most common source of complaint at 27.8% was resident/patient/client. Anonymous sources contributed a sizeable share for urban and rural hospitals, 10.7% and 11.1% respectively.

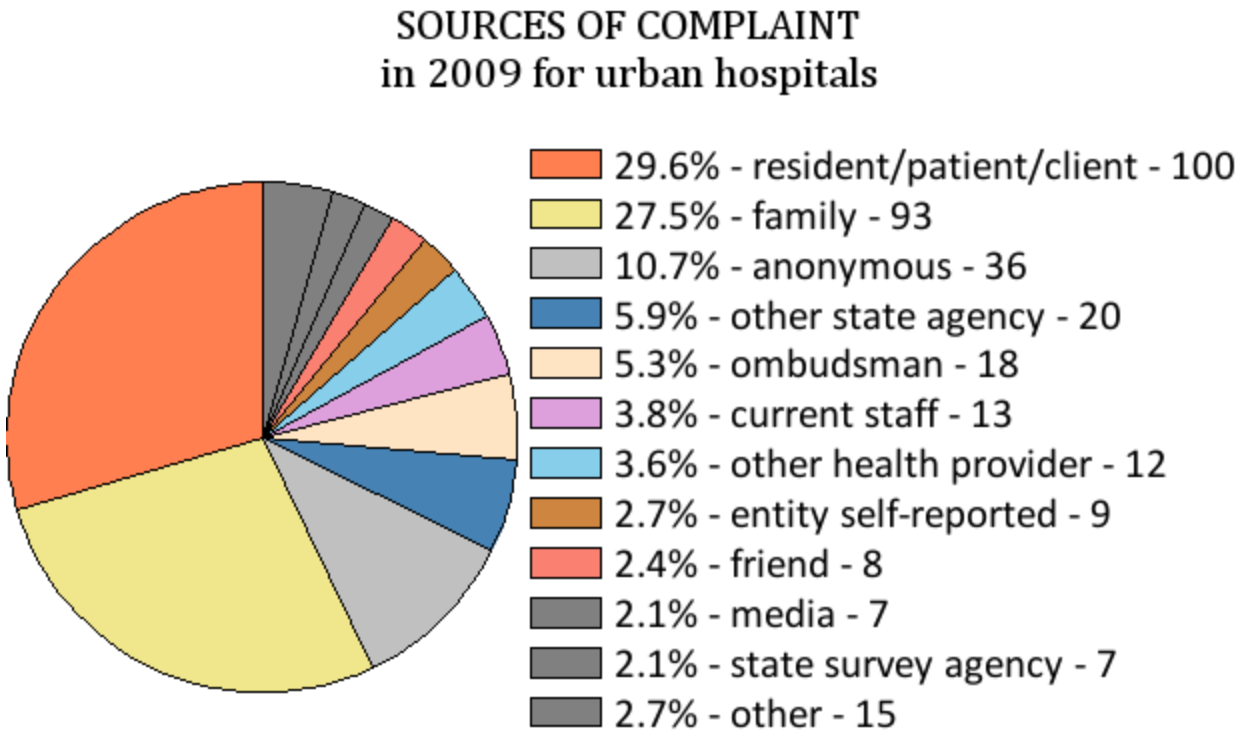

Figure 6

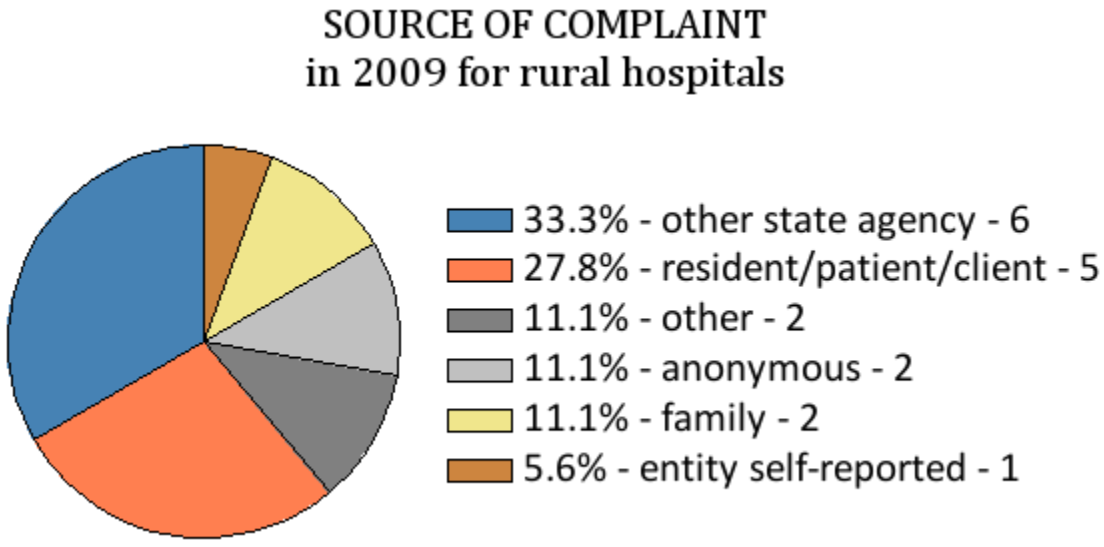

Figure 7

Figure 8 and Figure 9 below represent the modes of complaint for urban and rural hospitals. For both, telephone was used most frequently, accounting for nearly three-fifths of all complaints alone for urban hospitals and almost two-fifths for rural hospitals. The next most frequent modes of complaint were written and email for urban hospitals and written and fax for rural hospitals.

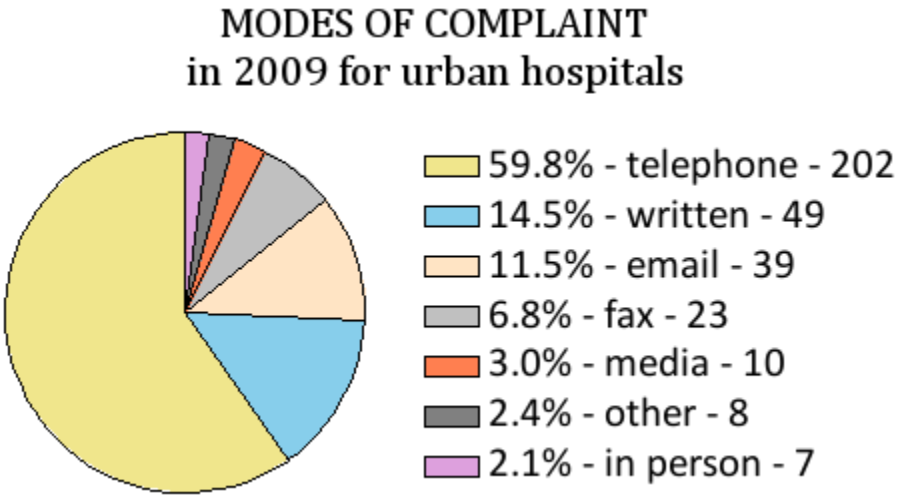

Figure 8

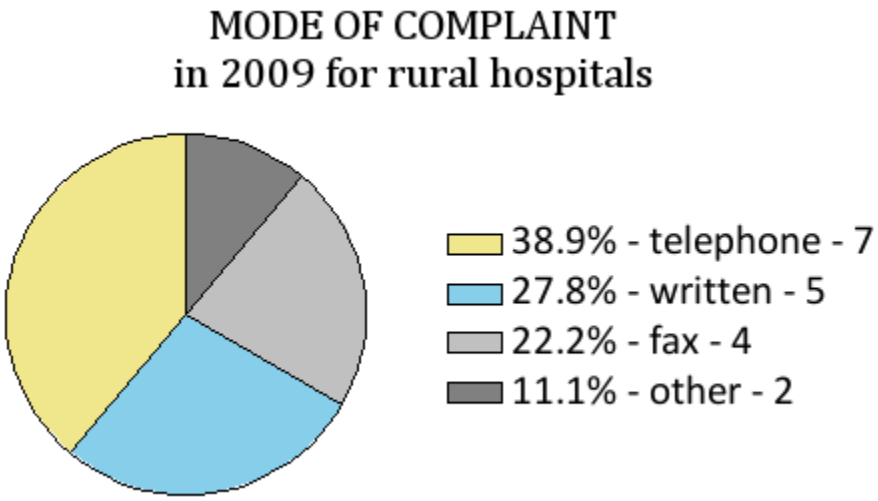

Figure 9

In 2009, 356 complaints were received against urban and rural hospitals, 338 against urban hospitals and 18 against rural hospitals. A break-down of the number and share of complaints against each of the various hospital types follows in Table 5.

SHARE OF COMPLAINTS
in 2009 against the various hospital types

how to read this table:

This table shows the share of complaints received against each hospital type.

COMPLAINTS BY HOSPITAL CLASSIFICAITON (January 1, 2009 – December 31, 2009)		
classification	**#**	**%**
Medical	13 of 15	86.7%
Surgical	1 of 1	100.0%
Psychiatric	8 of 11	72.7%
Medical-Surgical	8 of 12	66.7%
Medical-Surgical-Psychiatric	1 of 1	100.0%
General	18 of 20	90.0%

Table 5

In 2009, 91.1% of urban hospitals had complaints filed against them. No complaints were received for the following urban hospitals:

- Dini-Townsend Hospital At Northern Nevada Adult Mental Health Services
- Lake's Crossing Center
- Spring Mountain Sahara
- Tahoe Pacific Hospitals – West

In 2009, 53.3% of rural hospitals had complaints filed against them. No complaints were received for the following rural hospitals:

- Battle Mountain General Hospital
- Grover C Dils Medical Center
- Humboldt General Hospital
- Incline Village Community Hospital
- Mesa View Regional Hospital
- Nye Regional Medical Center
- South Lyon Medical Center

When an investigation is initiated in response to a complaint, the assigned inspector examines any evidence supporting the allegations associated with the complaint and inspects the pertinent aspects of the facility to determine whether any of the allegations, and therefore complaint, can be substantiated. During the course of an investigation, other deficiencies not related to the complaint but observed by the inspector may be cited; furthermore, a full federal or state inspection that had not been anticipated may be triggered should the inspector determine that enough deficiencies exist to merit such a follow-up inspection.

It should be noted that a substantiated allegation does not mean that a law or regulation was violated. All complaints and their allegations are investigated; however, not all correspond to a statutory or regulatory requirement. Moreover, an unsubstantiated allegation does not mean that the allegation was unfounded or that a law or regulation was not violated. An unsubstantiated allegation may mean any of the following:

- The allegation did not occur.
- There is insufficient evidence to substantiate the allegation.
- The allegation will be referred to the appropriate agency.

For urban and rural hospitals, Figure 10 and Figure 11 below show the percentage of all complaints substantiated, meaning that at least one allegation associated with the complaint was substantiated by an inspector. The proportion of complaints that are ultimately substantiated ranges from about a third for urban hospitals to almost two-fifths for rural hospitals.

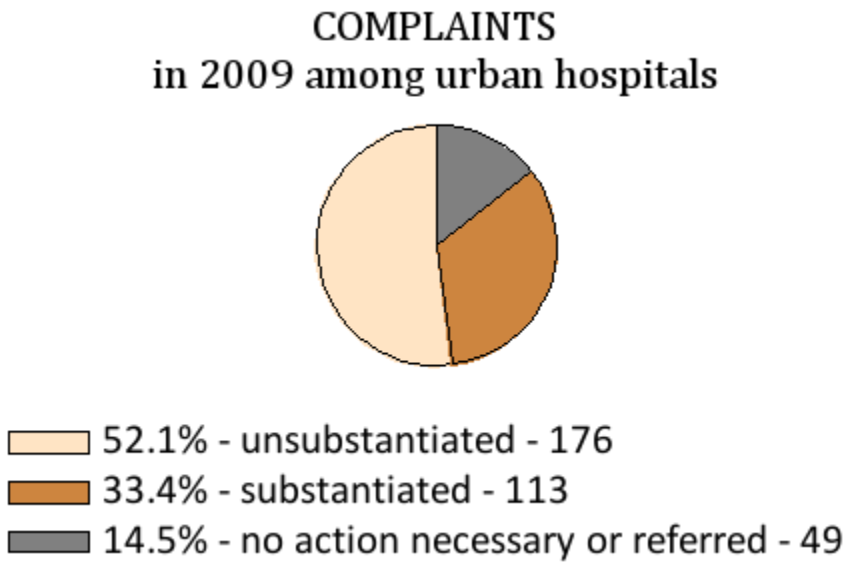

Figure 10

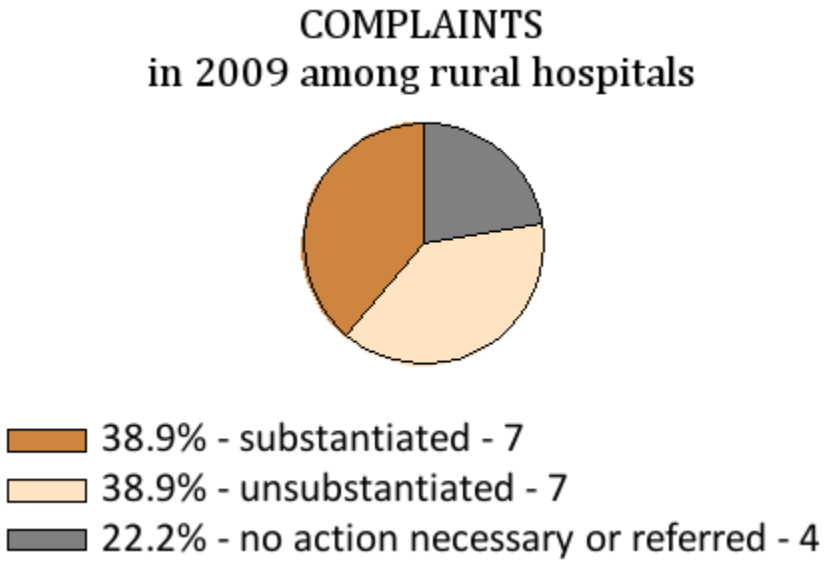

Figure 11

When a complaint allegation is substantiated and corresponds to a statutory or regulatory requirement, the inspected facility is cited and issued a statement of deficiencies. Figure 12 and Figure 13 show the share of all complaints for which at least one allegation was both substantiated and corresponded to an unmet legal requirement. Among urban hospitals, 7.4% of all complaints resulted in deficiency citations, while the share was larger among rural hospitals at 16.7%.

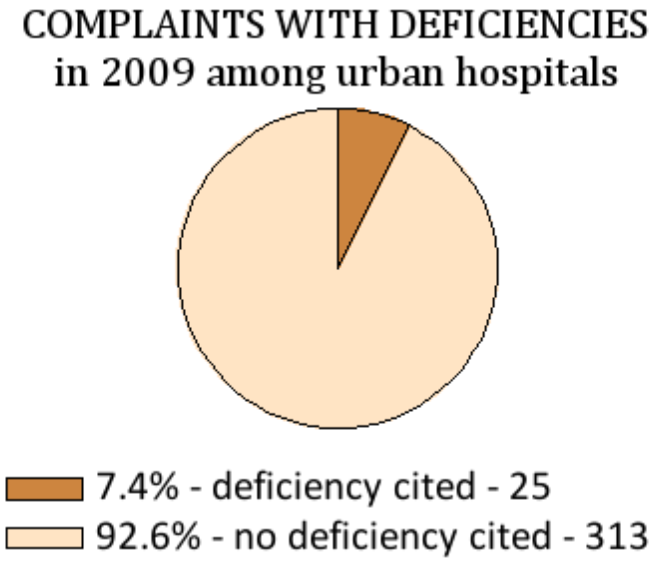

Figure 12

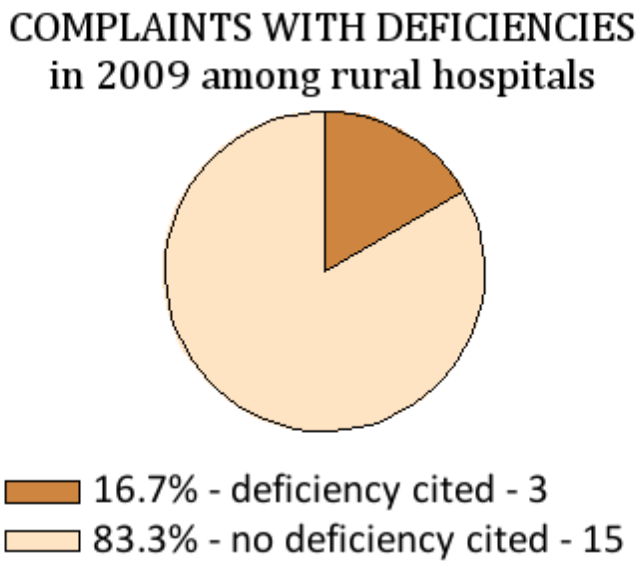

Figure 13

If considering just substantiated complaints, it is clear that those with deficiencies cited constitute a larger share than when considering all complaints overall, as Figure 14 and Figure 15 demonstrate. Among urban hospitals, 22.1% of substantiated complaints resulted in deficiency citations. Among rural hospitals, the figure was almost double, 42.9%, that of hospitals, suggesting that the allegations of substantiated complaints at rural hospitals are more likely to correspond to a statutory or regulatory deficiency.

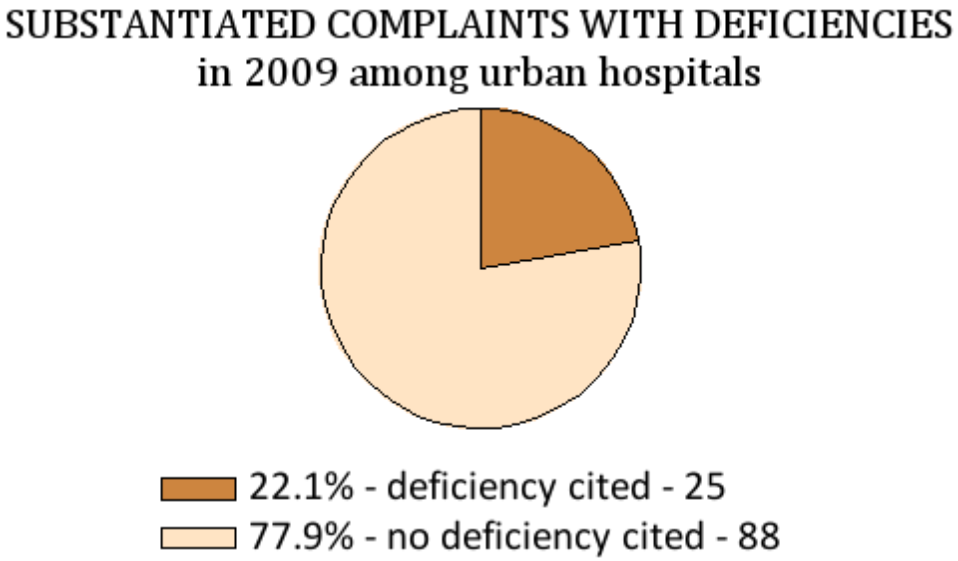

Figure 14

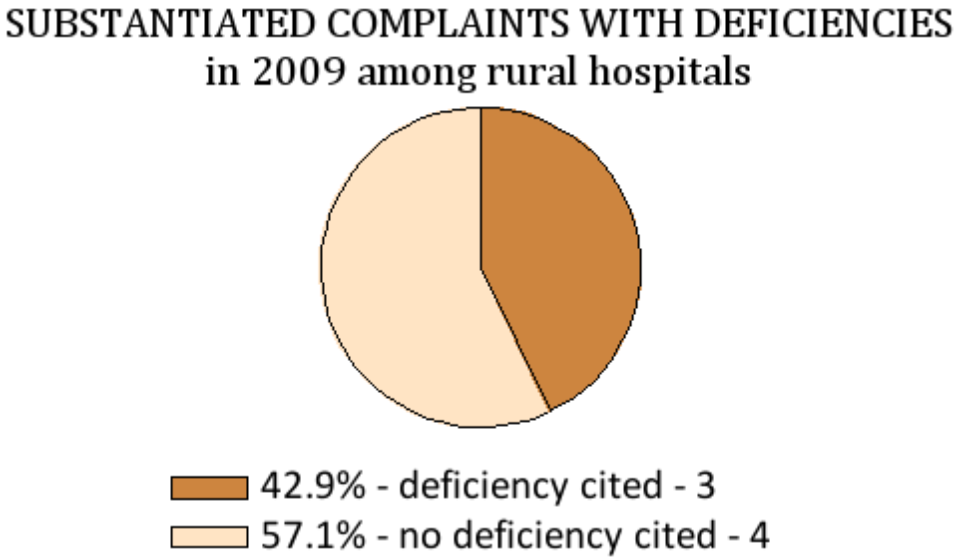

Figure 15

In 2009, there were 659 allegations associated with the 356 complaints received—632 against urban hospitals, 27 against rural hospitals. Of the 659 allegations, 156 were substantiated. Table 6 and Table 7 below show the number and percentage of allegations by allegation status.

ALLEGATIONS
in 2009 against urban hospitals

how to read this table:

This table shows the number of allegations by status associated with complaints against urban hospitals, including the allegation finding and frequency and percentage for each allegation.

COMPLAINT ALLEGATIONS (January 1, 2009 – December 31, 2009)		
finding	**#**	**%**
unsubstantiated	419	66.3%
substantiated	145	22.9%
referred	42	6.6%
no action necessary	8	1.3%
other	18	2.8%

Table 6

ALLEGATIONS
in 2009 against rural hospitals

how to read this table:

This table shows the number of allegations by status associated with complaints against rural hospitals, including the allegation finding and frequency and percentage for each allegation.

COMPLAINT ALLEGATIONS (January 1, 2009 – December 31, 2009)		
finding	**#**	**%**
unsubstantiated	13	48.1%
substantiated	11	40.7%
referred	2	7.4%
no action necessary	1	3.7%

Table 7

On the following pages, Figure 16, Figure 17, and Figure 18 show the frequency of each allegation against all hospitals, urban hospitals, and rural hospitals.

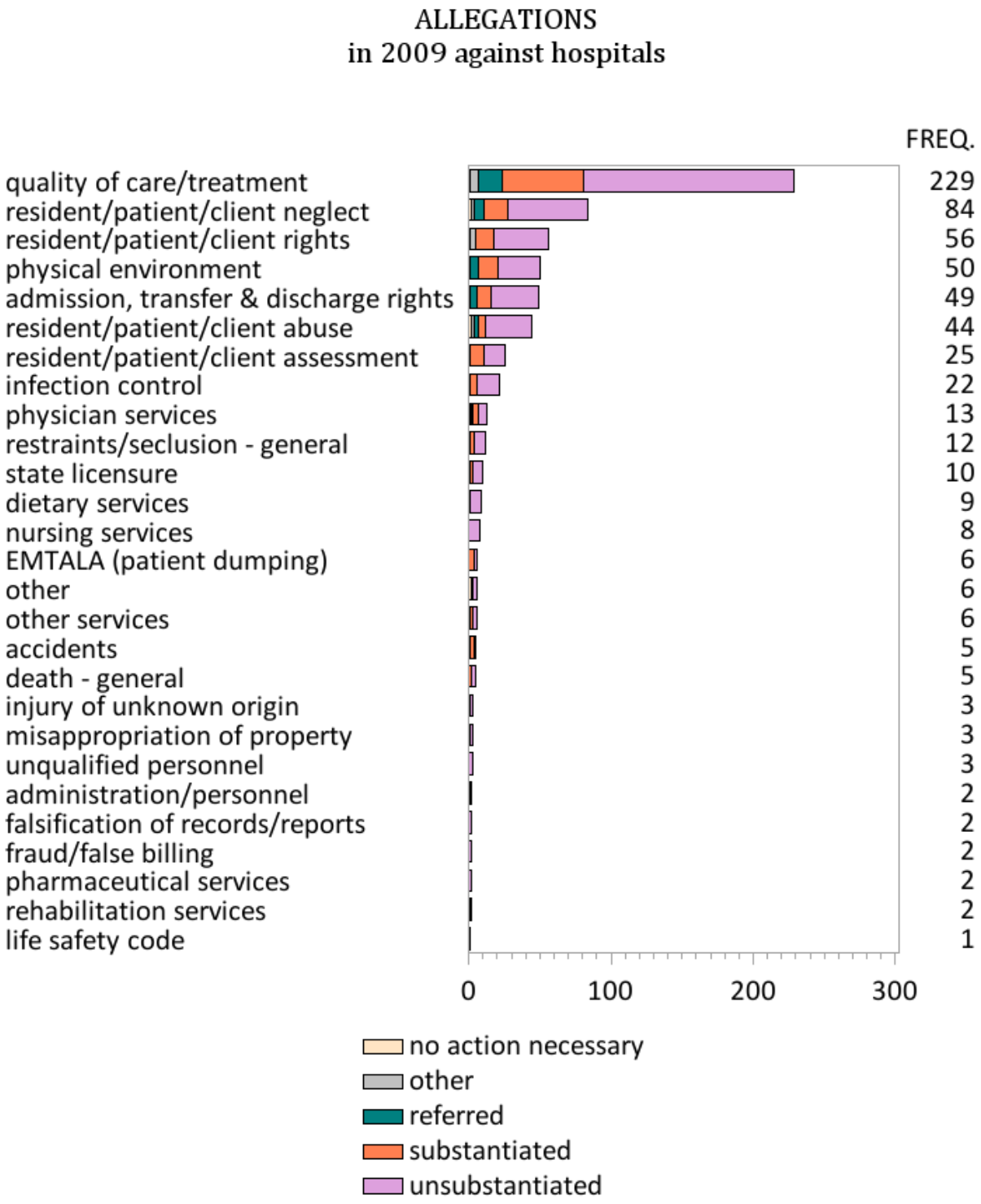
ALLEGATIONS
in 2009 against hospitals
FREQ.
quality of care/treatment 229
resident/patient/client neglect 84
resident/patient/client rights 56
physical environment 50
admission, transfer & discharge rights 49
resident/patient/client abuse 44
resident/patient/client assessment 25
infection control 22
physician services 13
restraints/seclusion - general 12
state licensure 10
dietary services 9
nursing services 8
EMTALA (patient dumping) 6
other 6
other services 6
accidents 5
death - general 5
injury of unknown origin 3
misappropriation of property 3
unqualified personnel 3
administration/personnel 2
falsification of records/reports 2
fraud/false billing 2
pharmaceutical services 2
rehabilitation services 2
life safety code 1
0
100
200
300
no action necessary
other
referred
substantiated
unsubstantiated

Figure 16

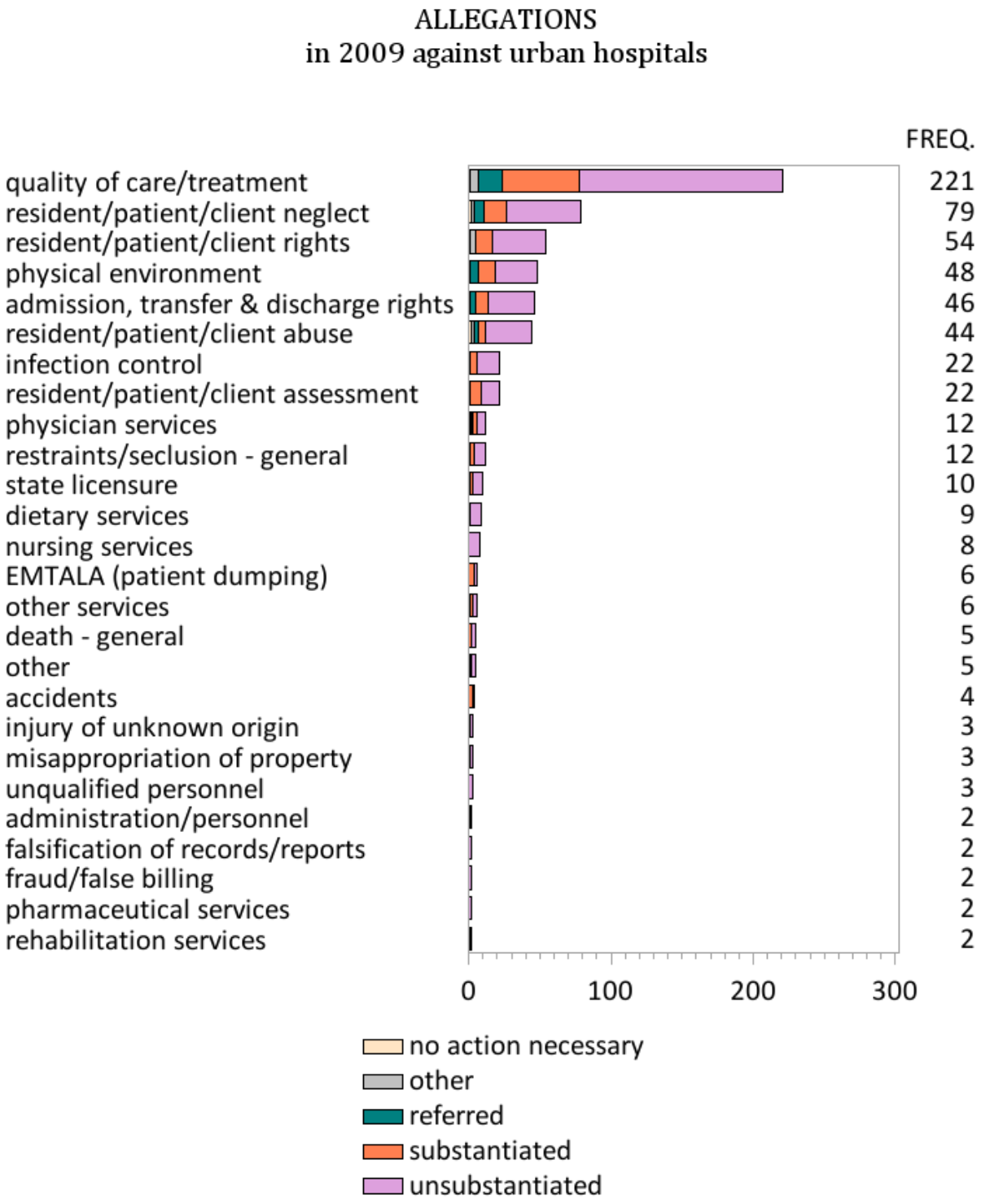
ALLEGATIONS
in 2009 against urban hospitals
FREQ.
quality of care/treatment 221
resident/patient/client neglect 79
resident/patient/client rights 54
physical environment 48
admission, transfer & discharge rights 46
resident/patient/client abuse 44
infection control 22
resident/patient/client assessment 22
physician services 12
restraints/seclusion - general 12
state licensure 10
dietary services 9
nursing services 8
EMTALA (patient dumping) 6
other services 6
death - general 5
other 5
accidents 4
injury of unknown origin 3
misappropriation of property 3
unqualified personnel 3
administration/personnel 2
falsification of records/reports 2
fraud/false billing 2
pharmaceutical services 2
rehabilitation services 2
0
100
200
300
no action necessary
other
referred
substantiated
unsubstantiated

Figure 17

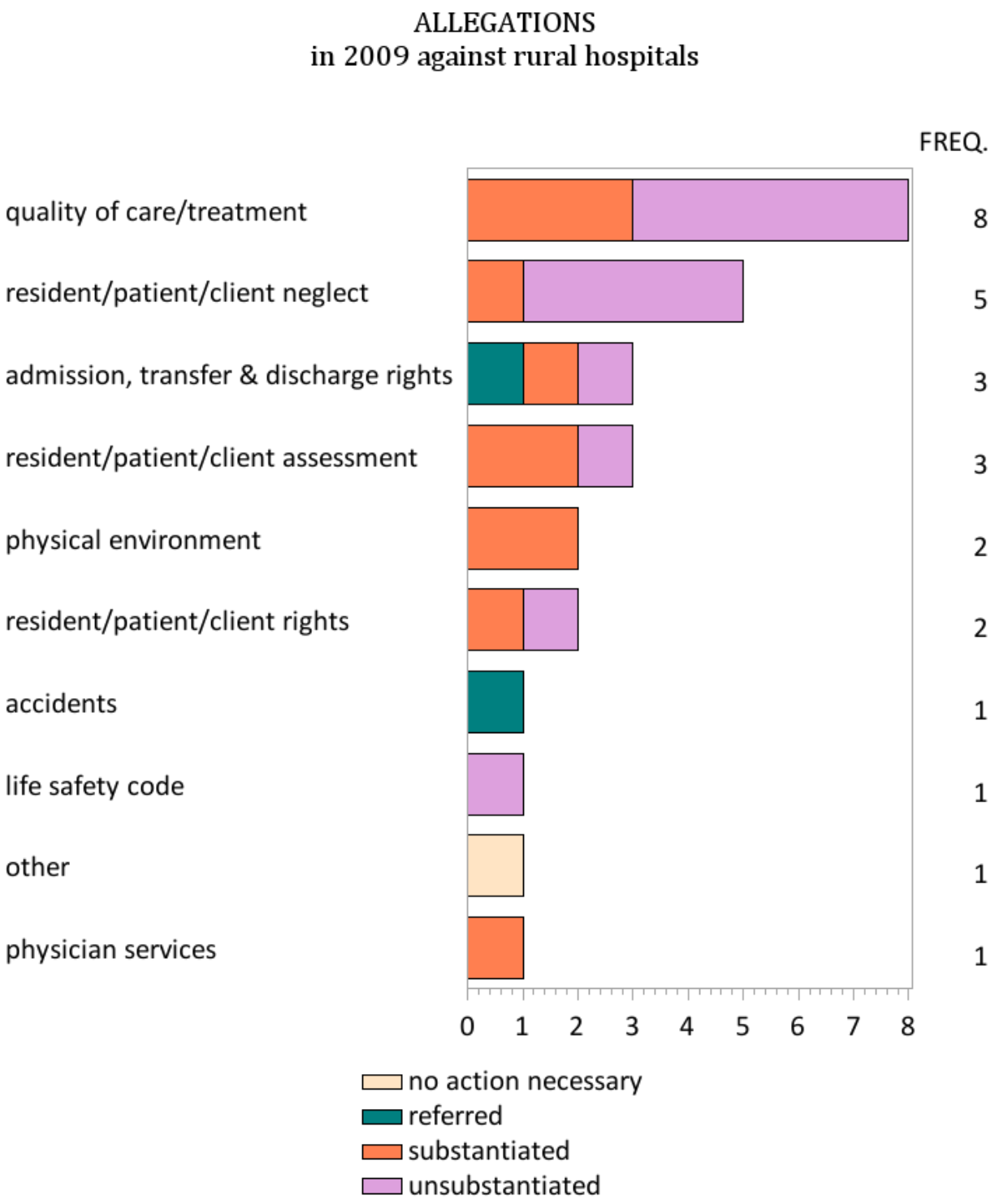
ALLEGATIONS
in 2009 against rural hospitals
FREQ.
quality of care/treatment
8
resident/patient/client neglect
5
admission, transfer & discharge rights
3
resident/patient/client assessment
3
physical environment
2
resident/patient/client rights
2
accidents
1
life safety code
1
other
1
physician services
1
0 1 2 3 4 5 6 7 8
no action necessary
referred
substantiated
unsubstantiated

Figure 18

For all hospitals, the most common allegations were related to:

1. quality of care/treatment
2. resident/patient/client neglect
3. resident/patient/client rights

In terms of substantiated allegations, the most common allegations were similar:

1. quality of care/treatment
2. resident/patient/client neglect
3. resident/patient/client rights
4. admission, transfer, and discharge rights

On the following pages, Figure 19 and Figure 20 show the frequency of deficiencies cited as a result of a complaint investigation. This offers a different perspective from the overall, facility-specific deficiencies reported earlier.

From a complainant's perspective, the most frequently identified deficiency among urban hospitals was related to *discharge planning*, followed by *assessment of patient*. *Appropriate care of patient* and *nursing service* rank equally as the third most commonly complainant-identified deficiency.

The most frequently identified deficiencies among rural hospitals were related to both *discharge planning* and *social services*, followed equally by *appropriate care of patient*, *assessment of patients*, *nursing service* and *physical environment*.

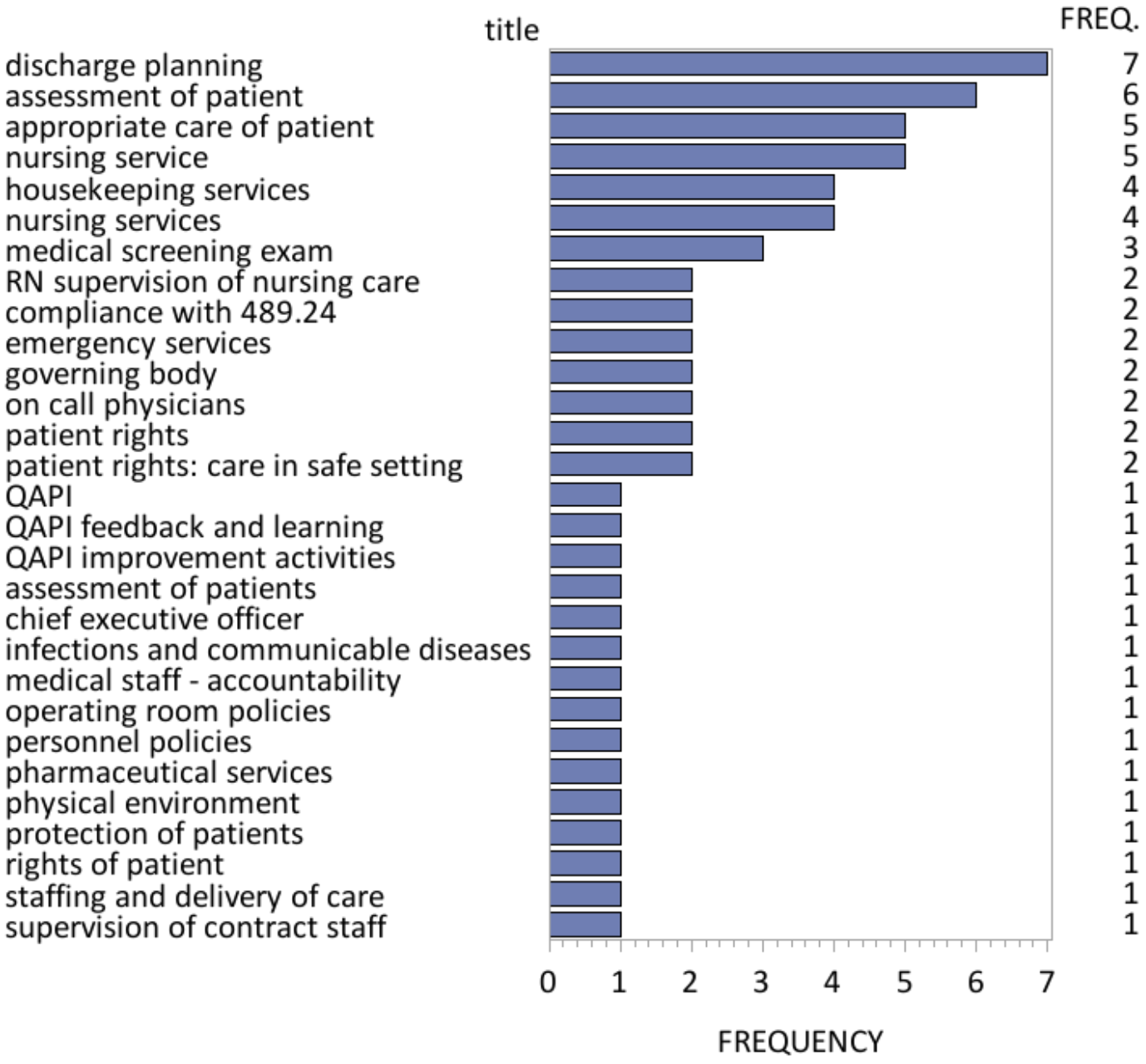
DEFICIENCIES CITED FOLLOWING COMPLAINT INVESTIGATION
in 2009 among urban hospitals
title
FREQ.
discharge planning 7
assessment of patient 6
appropriate care of patient 5
nursing service 5
housekeeping services 4
nursing services 4
medical screening exam 3
RN supervision of nursing care 2
compliance with 489.24 2
emergency services 2
governing body 2
on call physicians 2
patient rights 2
patient rights: care in safe setting 2
QAPI 1
QAPI feedback and learning 1
QAPI improvement activities 1
assessment of patients 1
chief executive officer 1
infections and communicable diseases 1
medical staff - accountability 1
operating room policies 1
personnel policies 1
pharmaceutical services 1
physical environment 1
protection of patients 1
rights of patient 1
staffing and delivery of care 1
supervision of contract staff 1
0 1 2 3 4 5 6 7
FREQUENCY

Figure 19

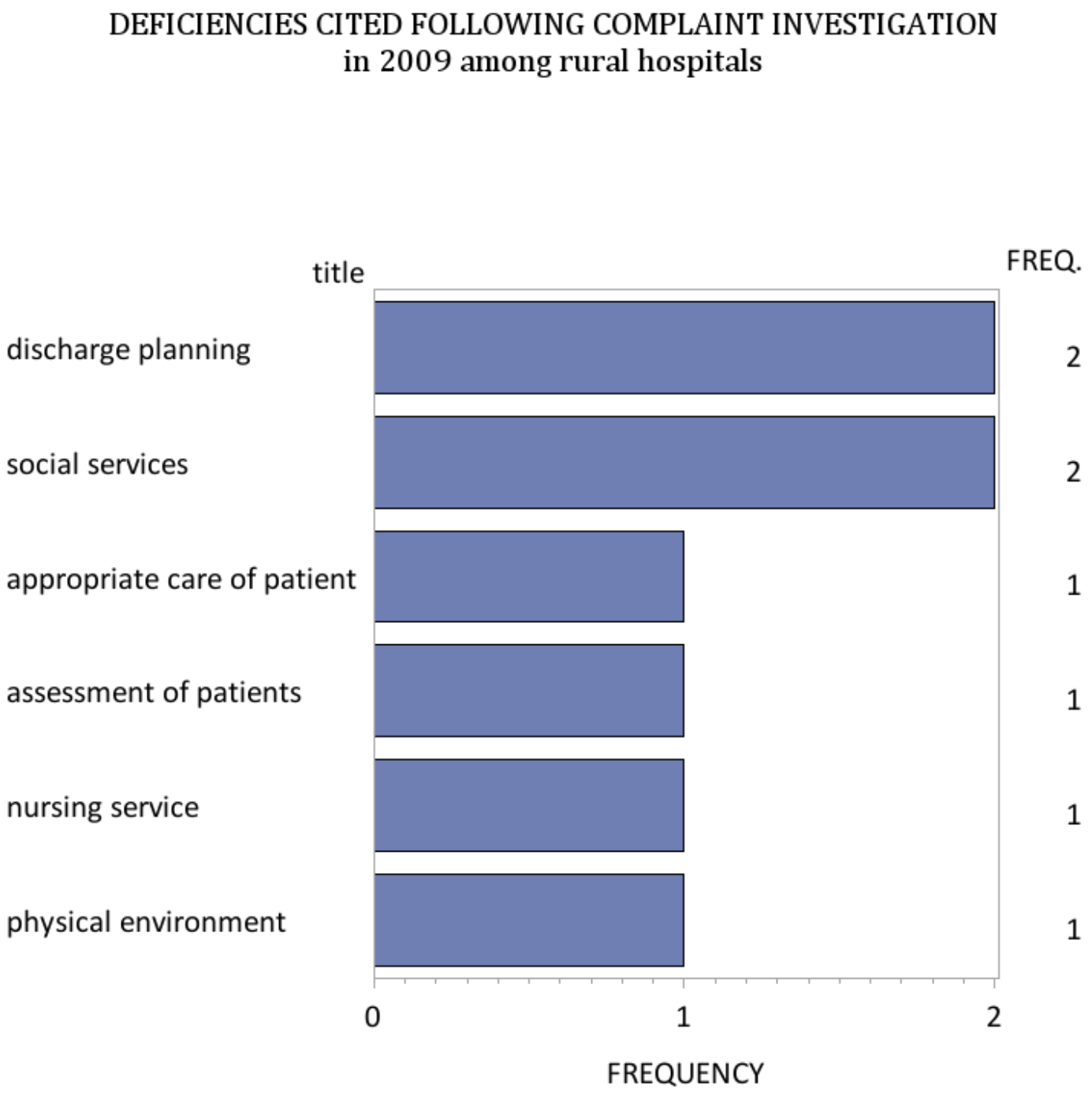
DEFICIENCIES CITED FOLLOWING COMPLAINT INVESTIGATION
in 2009 among rural hospitals
title
FREQ.
discharge planning
2
social services
2
appropriate care of patient
1
assessment of patients
1
nursing service
1
physical environment
1
0
1
2
FREQUENCY

Figure 20

Sentinel Events Registry

NRS 439.830 defines a sentinel event as:

> an unexpected occurrence involving facility-acquired infection, death or serious physical or psychological injury or the risk thereof, including, without limitation, any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. The term includes loss of limb or function.

The Sentinel Events Registry is a database used to collect, analyze, and evaluate such adverse events. The intent is that the reporting of these sentinel events will reveal systemic issues across facilities so that they may be addressed more widely through quality improvement and educational activities.

NRS 439.835 requires that medical facilities report sentinel events to NSHD. As specified in NRS 439.805, the medical facility types required to report sentinel events are as follows:

- hospitals
- obstetric centers
- surgical centers for ambulatory patients
- independent centers for emergency medical care

Hospitals reported 201 sentinel events in 2009. Figure 21 shows their share, 82.4%, of all sentinel event reports that year.

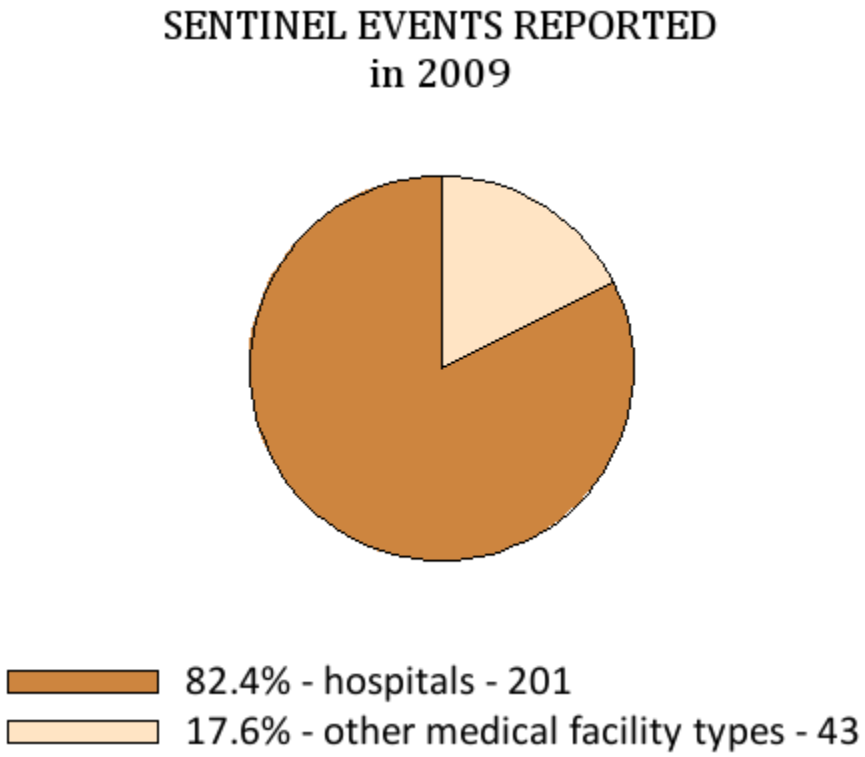

Figure 21

Sentinel events are categorized by the type of event that occurred. Within some of these categories are further specifics regarding the type of event. Table 8 shows the number of sentinel events reported by each sub-category, and Figure 22 on the following page depicts the reports by both the overall category and sub-category.

SENTINEL EVENTS REPORTED
in 2009 among hospitals

how to read this table:

This table shows the number of sentinel events reported by category, including the category name and frequency of each.

SENTINEL EVENTS REPORTED (January 1, 2009 – December 31, 2009)			
event type	**#**	**event type**	**#**
abduction	0	impersonation of health-care professional	0
assault (attempted battery)	1	infant perinatal	1
battery	0	maternal intrapartum	3
burn	4	medication error(s)	7
contaminated product/device	5	procedure complication(s)	20
discharge to wrong family/caregiver	0	rape	0
electric shock (environmental)	0	rape – attempted	0
elopement	5	restraint	1
HAI – catheter-related urinary tract infection	5	retained foreign object	9
HAI – central line-related bloodstream infection	5	suicide	4
HAI – decubitus ulcer (stage 3 or 4)	4	suicide – attempted	10
HAI – non-catheter-related urinary tract infection	11	transfusion	1
HAI – non-central line-related bloodstream infection	1	treatment error	3
HAI – surgical site infection	16	wrong patient/wrong surgery procedure	1
HAI – ventilator-associated pneumonia	1	wrong site/surgery procedure	4
fall	35	HAI – other	9
homicide	0	other	23
homicide – attempted	0		

Table 8

Figure 22 below shows the proportion of sentinel events reported by event type category—represented by the pie slices. For those categories that have sub-category details, the specific event type is represented within the overall category by the inner pie pieces.

The most common event type was HAI, accounting for 25.9% of all reports. Within the HAI event type category, surgical site infections (SSIs) were the dominant HAI at 8.0% of all reports followed by non-catheter-associated urinary tract infections (CAUTIs) at 5.5%. Central-line-associated bloodstream infections (CLABSIs) were the smallest sub-category within HAIs. Falls were the second most common event type at 17.4%. Procedure complications and treatment issues amounted to 10.0% and 7.5% respectively, with the major part of the treatment category attributable to treatment delay. Suicide events followed closely behind treatment issues at 7.0%, though most were not completed.

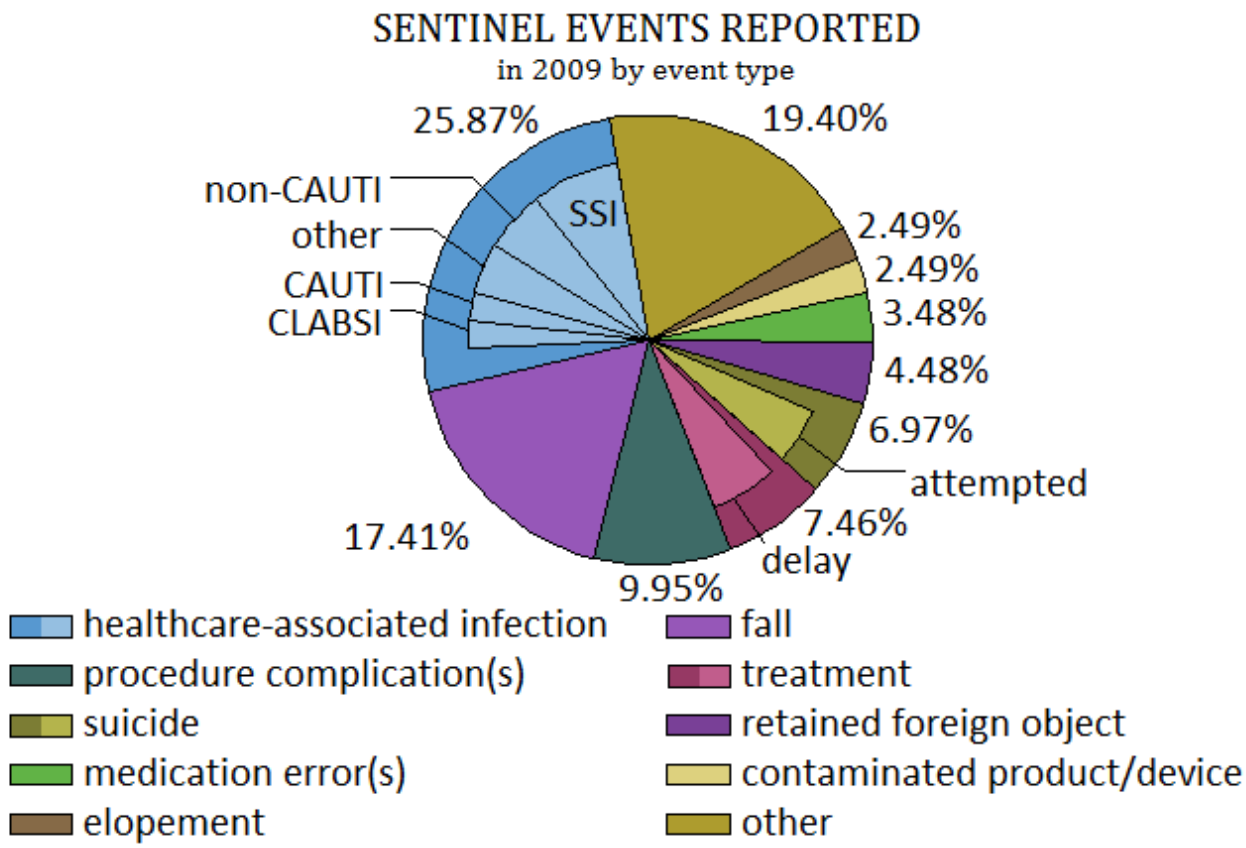

Figure 22

Overall, 46.3% of sentinel events involved actual or risk of physical injury. Death was the second most common outcome risk, at 27.9%; while HAIs accounted for 22.4% of sentinel events reported.

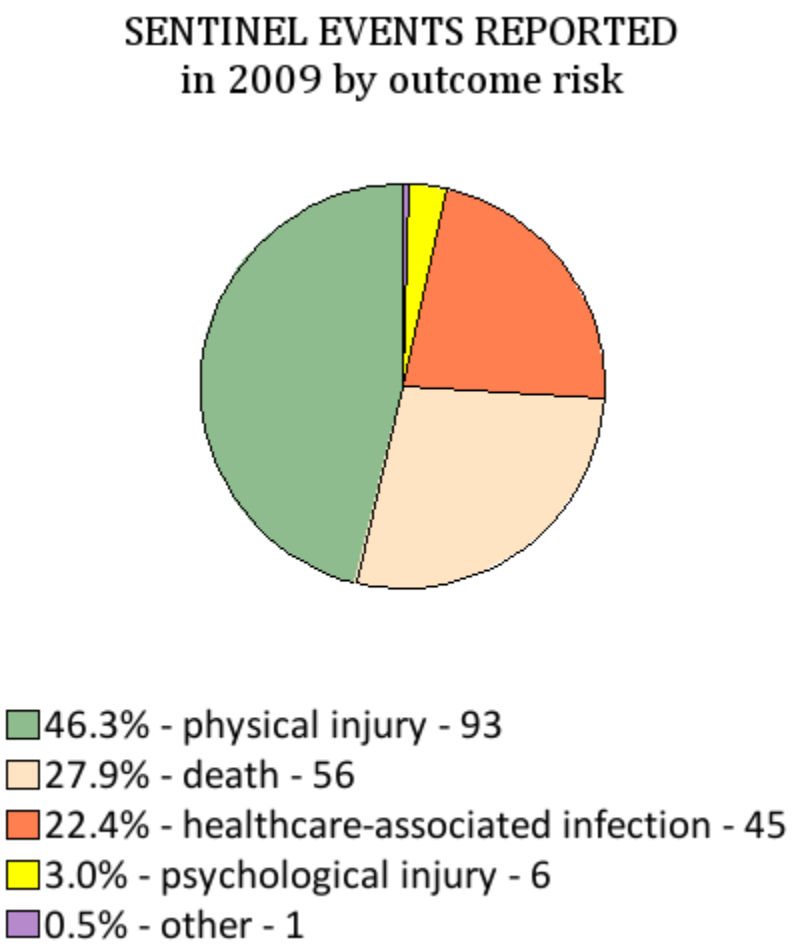

Figure 23

Figure 24 and Figure 25 represent actual and risk of outcomes for the sentinel events reported. Among the sentinel events with an actual adverse outcome, HAI[2] and death were the most common, at comparable proportions of 43.3% and 40.4%, respectively. Physical injury followed at 15.4%. Among those that posed a risk of an adverse outcome, physical injury accounted for almost two-fifths of the share. Risk of death followed at 14.4%.

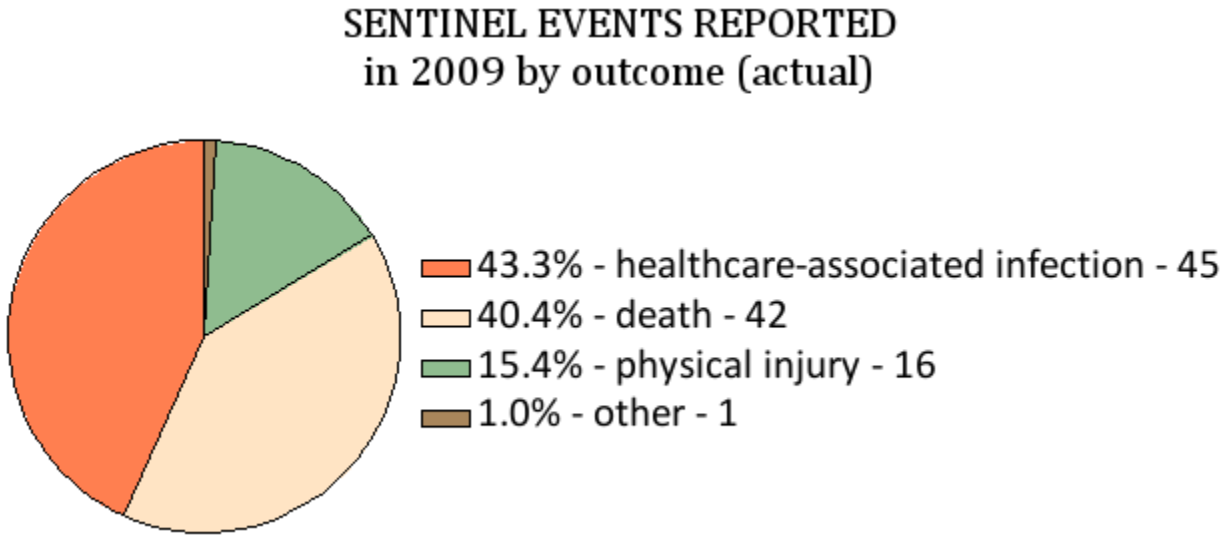

Figure 24

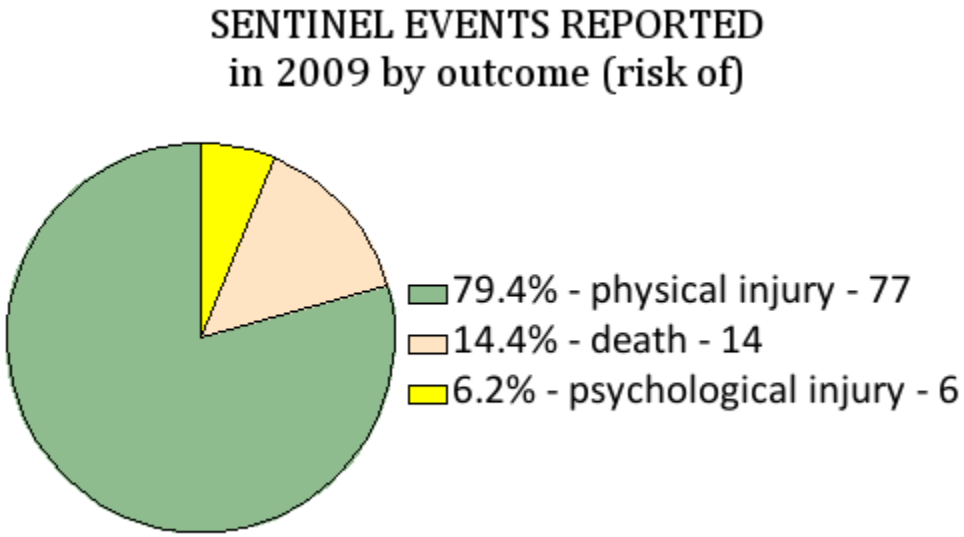

Figure 25

[2] Due to the poor wording on the form for this selection, it is somewhat ambiguous whether these were actual or risk of, though the language lent itself to actual infection; therefore, for the purposes of this analysis, reports involving healthcare-associated were presumed to be actual. The ambiguity was eliminated when the form was revised in October 2010.

Of the sentinel events reported by urban and rural hospitals, 93.5% were ultimately determined to have at least one contributing factor. Figure 26 shows the reported contributing factor categories. Note that the bars do not sum to 100% as sentinel events may have more than one contributing factor.

Patient-related contributing factors were the dominant contributing factor category, accounting for 37.7% of all reports, followed by staff-related contributing factors at 26.1%, and communication/documentation at 19.3%.

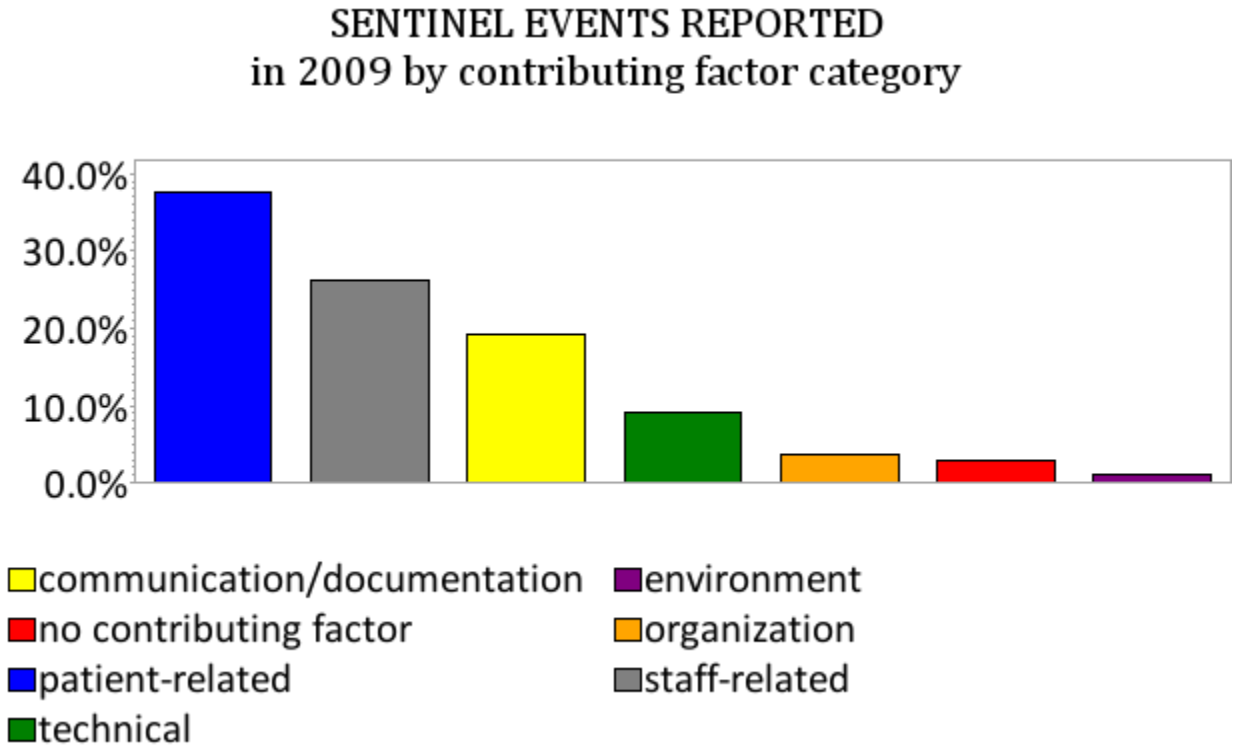

Figure 26

On the following 3 pages, Figure 27, Figure 28, and Figure 29 show each of the top 3 contributing factor categories: patient-related, staff-related, and communication/documentation, with the specific contributing factors that comprise each. Since multiple specific contributing factors are possible for each event, the sum of the percentages shown may exceed 100%.

Within the patient-related category, frailty/unsteadiness was the main contributing factor at 41.3% of all patient-related contributing factors. Patient non-compliance was next at 35.6%, followed by physical impairment at 27.9%. Confusion and self-harm were the remaining contributing factors, each accounting for 18.3%.

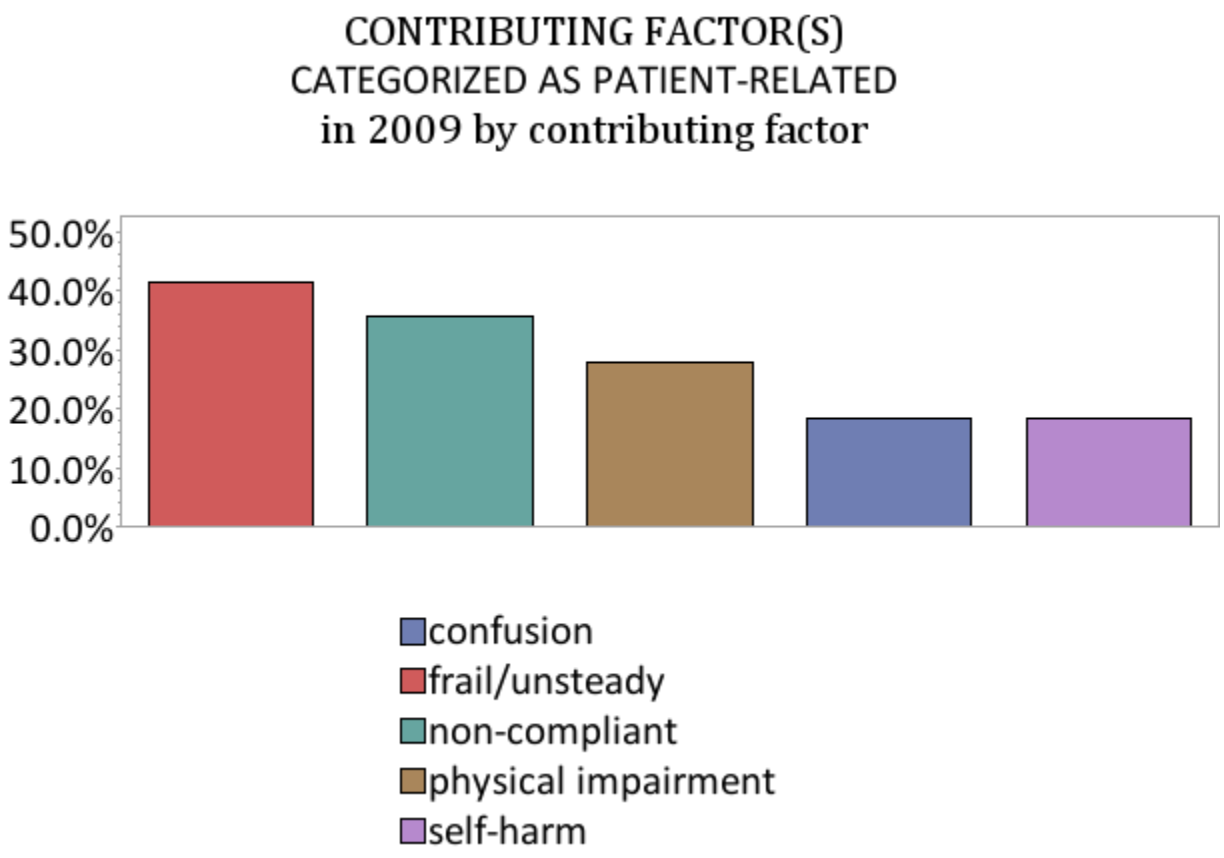

Figure 27

Within the staff-related category, failure to follow policy and/or procedure was the major contributing factor at 54.8% of all staff-related contributing factors. A substantial share were attributable to clinical decision/assessment at 45.2%, and 21.5% were due to clinical performance/administration.

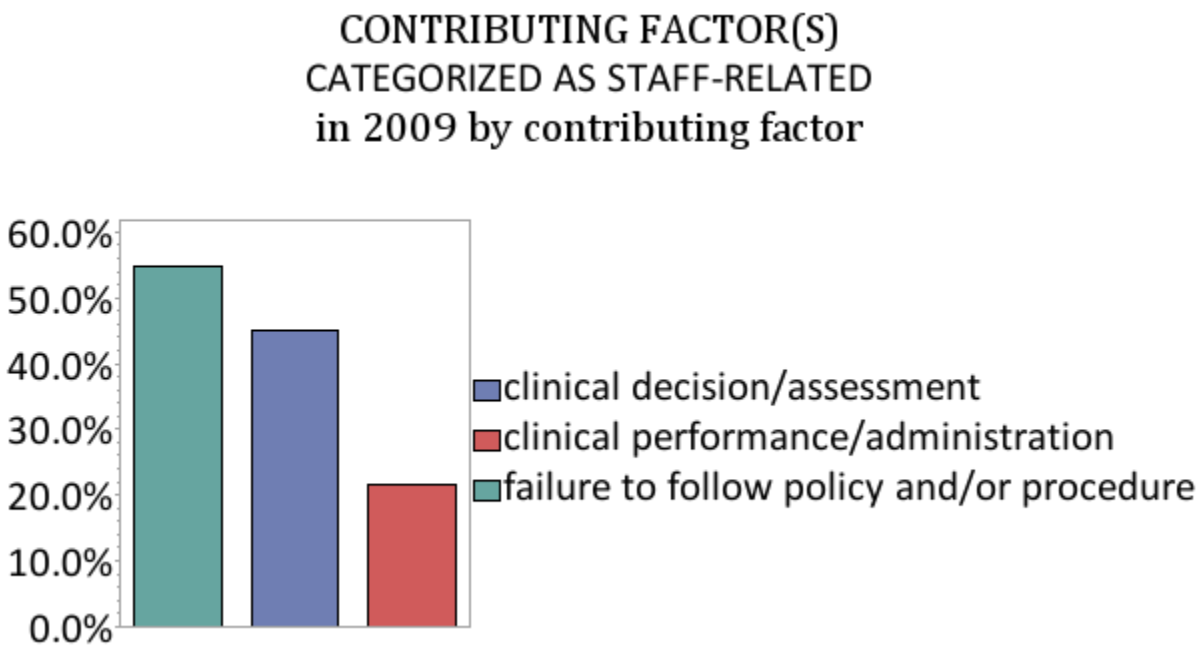

Figure 28

Within the communication/documentation category, hand-off/teamwork/cross-coverage was the main factor at 38.7%. Lack of communication accounted for 27.4% followed closely by inadequate verbal communication at 25.8%. Lack of/inadequate documentation and inadequate written communication were also fairly substantial at 21.0% and 19.4% respectively.

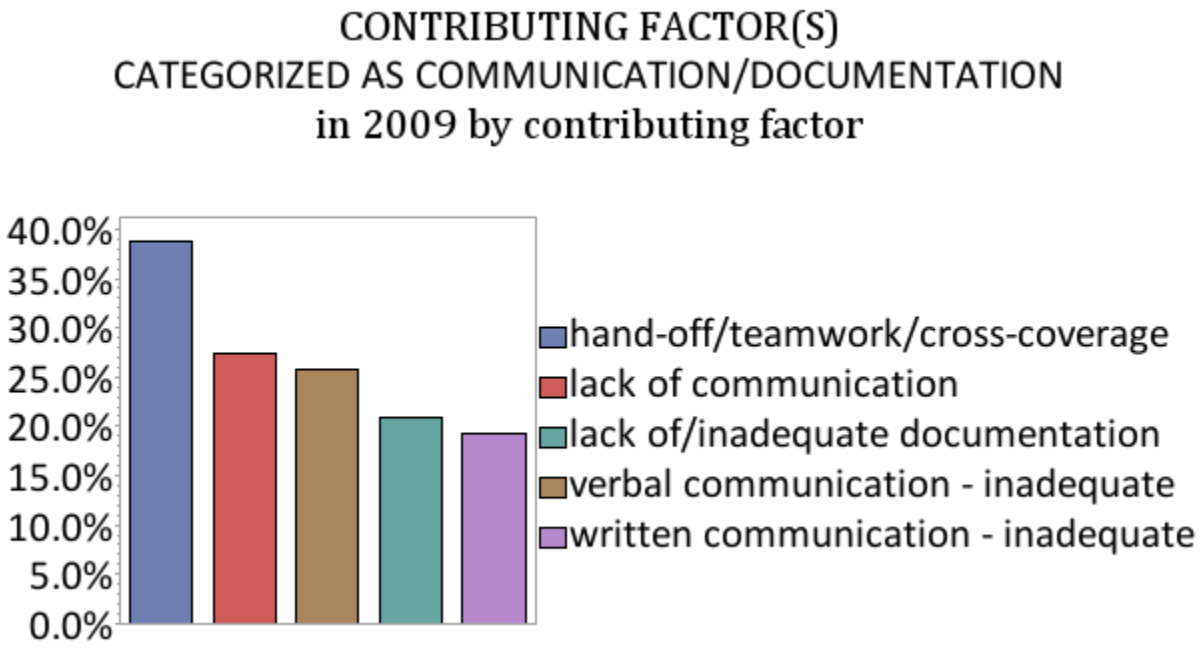

Figure 29

To examine where sentinel events occurred, they were grouped by department of occurrence. Figure 30 below shows the major departments of occurrence.

At nearly a quarter, medical/surgical departments were the most common location for a sentinel event to occur. Psychological/behavioral health/geropsychological departments accounted for the next highest at 13.9%, followed closely by long term care departments. At 11.4%, inpatient surgery was also a significant location for sentinel events to occur.

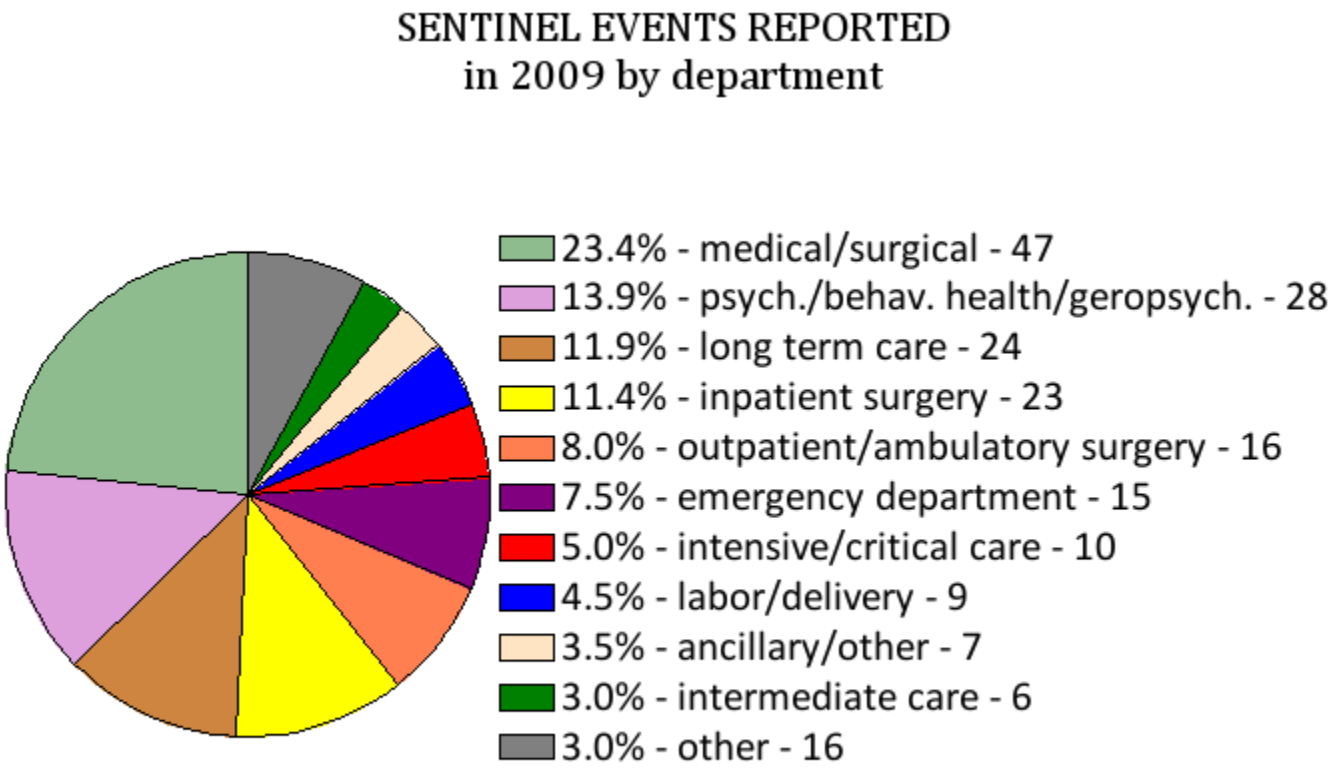

Figure 30

Another purpose of sentinel event reporting is to encourage healthcare facilities to analyze the underlying issues which contributed to sentinel event occurrence. As such, NSHD requires that facilities report the corrective actions they take in response to a sentinel event. Table 9 below shows the top 10 corrective actions taken by hospitals in 2009. Staff education/in-service training and situation analysis ranked high at 55.2% and 39.3% respectively.

TOP 10 CORRECTIVE ACTIONS in 2009 among hospitals

how to read this table:

This table shows the top ten corrective actions taken by hospitals in response to the occurrence of a sentinel event, including the category of the corrective action and a percentage of the total for each.

TOP 10 CORRECTIVE ACTIONS (January 1, 2009 – December 31, 2009)	
corrective action	**% of sentinel events reported**
staff education/in-service training	55.2%
situation analysis	39.3%
policy review	32.8%
process review	32.8%
procedure review	29.4%
process modification	19.4%
disciplinary action(s)	14.4%
policy modification	10.0%
environmental change(s)	8.5%
equipment modification(s)	7.5%
procedure modification	7.5%

Table 9

As a service to hospitals that may benefit from the sentinel event experience of other facilities, a select list of lessons learned is provided below which has been drawn from the actual lessons learned reported by healthcare facility personnel:

- Prepare for the possibility of psychotic incidents by equipping staff with alarm buttons and identifying escape routes for staff in advance.
- Ensure staff have effective communication devices such as 2-way radios.
- Standardize discharge policy and implement check-lists to assure correct implementation.
- Instruct staff to be vigilant in ensuring that patients receive and use incentive spirometers.
- Declare that staff are never to enter an operating room for equipment but that they should instead contact the house supervisor to obtain sterile equipment.
- Remove Foley catheters at the earliest available opportunity.
- Consider using silver-coated V-links to prevent central line-related bloodstream infections.
- Limit traffic in and out of high acuity patient rooms.
- Promptly remove medications that are to be discontinued from both the patient's medication administration record and the medication storage unit.
- Instruct both sending and receiving nurses to review all hanging intravenous medications to ensure that all high alert medications have a warning sticker applied to the bag and that they are labeled as either proximal or distal to the patient.
- Visually inspect sterile instruments before use, discarding questionable items.

Infection Risk Assessment Tool

Background

According to CDC, HAIs cause at least 99,000 deaths among about two million patients who contract these infections each year. Therefore, any efforts to reduce patients' risk to be exposed to or contract such infections will probably have an immediate impact on reducing the morbidity and mortality associated with HAIs and improving the quality of life for the patients and their families. Additionally, preventing HAIs will also ease the financial, societal, and public health heavy burden of this major public health concern.

Although HAIs are among the leading, most costly and most preventable causes of death in the United States, surprisingly, hospitals and other healthcare facilities have very limited or no resources to address this significant healthcare problem. When it comes to infection prevention, most hospitals in Nevada and nationwide are understaffed, do not have an adequate infrastructure, adequate resources, or plans to address such an emerging and evolving public health concern. Furthermore, outpatient surgery centers, ambulatory care centers, and long term care skilled nursing facilities rarely have any experienced staff to coordinate the extremely needed infection prevention programs.

The recent hepatitis C outbreak in Clark County resulted in numerous cases of hepatitis C; tens of thousands of potentially exposed individuals to blood-borne pathogens; and a formidable financial, societal, and emotional burden. Preventing and ultimately eliminating HAIs is a top priority for NSHD, and in order to ensure that a 'never event' such as that outbreak would never happen again, NSHD conducted numerous facility inspections and accomplished thorough evaluations of the healthcare and public health systems over the past two years. Multi-system failures and many gross imperfections were identified and currently it is quite obvious that no one single agency by itself has adequate resources, the proper expertise, or the means to address this issue and reverse the alarming trends of the HAI epidemic in Nevada. NSHD is directly collaborating with healthcare facilities of all sizes and specialties in order to identify, reduce, and eventually prevent modifiable risk factors and behaviors that could result or may lead to an increase in the patient's risk to contract or spread HAIs.

During the investigation of the hepatitis C outbreak and the detection of unsafe injection practices that resulted in subsequent inspections to all ambulatory surgery centers, NSHD epidemiology staff developed and successfully implemented the infection risk assessment survey tool. The survey tool was mainly used to enable state surveyors from BHCQC to identify inappropriate activities and behaviors that may lead to increasing risks for patients to contract or spread infections. This highly focused infection control tool helped surveyors to detect infection breeches and system failures that posed serious risks for the patients and healthcare providers as well. Unfortunately, in the past, such infection control breeches remained undetected as routine facility inspections required by CMS were not geared to detect infections and did not focus on preventing HAIs.

Findings from the Infection Risk Assessment Survey Tool

Currently, NSHD surveyors are proficient in using this tool during facility inspections. In 2009, 15 of the 60 hospitals in Nevada were surveyed (12 of the 45 urban and 3 of the 15 rural hospitals) as illustrated in Figure 31.

Thirteen of the 15 surveyed hospitals were accredited by TJC; while 2 hospitals, 1 urban and 1 rural, were not accredited at the time of inspection.

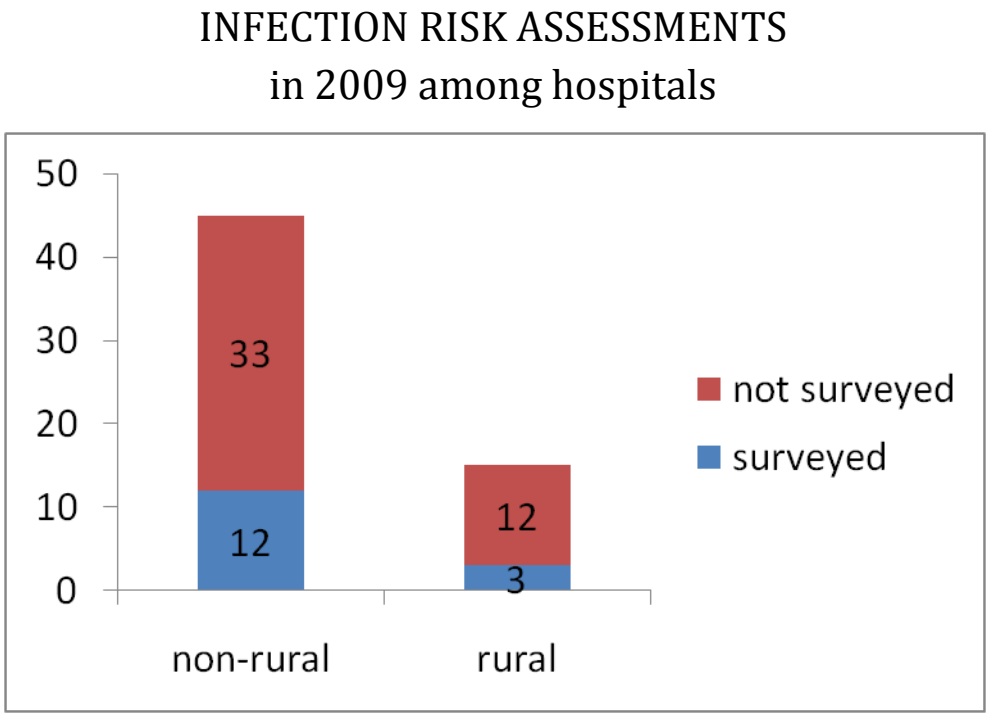

Figure 31

Procedures Performed

Surveyed hospitals varied by locations, size, complexity of services, and the number or diversity of endoscopic and other surgical/medical procedures performed. More than half of the facilities surveyed performed endoscopic procedures; 7 of them were urban and 1 was rural. General surgery; cardiovascular procedures; urology; ear, nose, and throat (ENT) procedures; and foot surgery were performed in 5 surveyed hospitals. Ophthalmologic interventions, thoracic surgery, pain management, and obstetrics-gynecology procedures were performed in 4 hospitals. Three of the hospitals surveyed reported performing plastic surgery, 6 hospitals performed orthopedic procedures, and 2 performed oral surgery as represented in Table 10.

PROCEDURES PERFORMED
in 2009 among surveyed hospitals

how to read this table:

This table shows the procedures performed among the 15 hospitals that had an infection risk assessment survey conducted.

PROCEDURES PERFORMED (January 1, 2009 – December 31, 2009)	
procedure	**number of hospitals**
cardiovascular	5
endoscopic	8
ears, nose, and throat	5
foot surgery	5
general surgery	5
obstetrics/gynecology	4
ophthalmologic	4
oral surgery	3
orthopedic	6
pain management	4
plastic surgery	3
thoracic surgery	4
urological	5

Table 10

Infection Control

Thirteen of the 15 surveyed hospitals had already developed a comprehensive infection control program. Both of the hospitals that did not have comprehensive infection control programs (1 urban and 1 rural) were in the process of building their internal capacity and plan to control HAIs.

Data available from the survey tool did not explicitly identify the number of infection control and prevention staff working in each facility. However, 8 hospitals (less than 54%) reported having one or more certified infection prevention specialists who were actively working to reduce the burden on HAIs. Seven of those were urban and 1 was rural as illustrated in Figure 32. All surveyed facilities reported providing annual training and regular updates for their infection control staff.

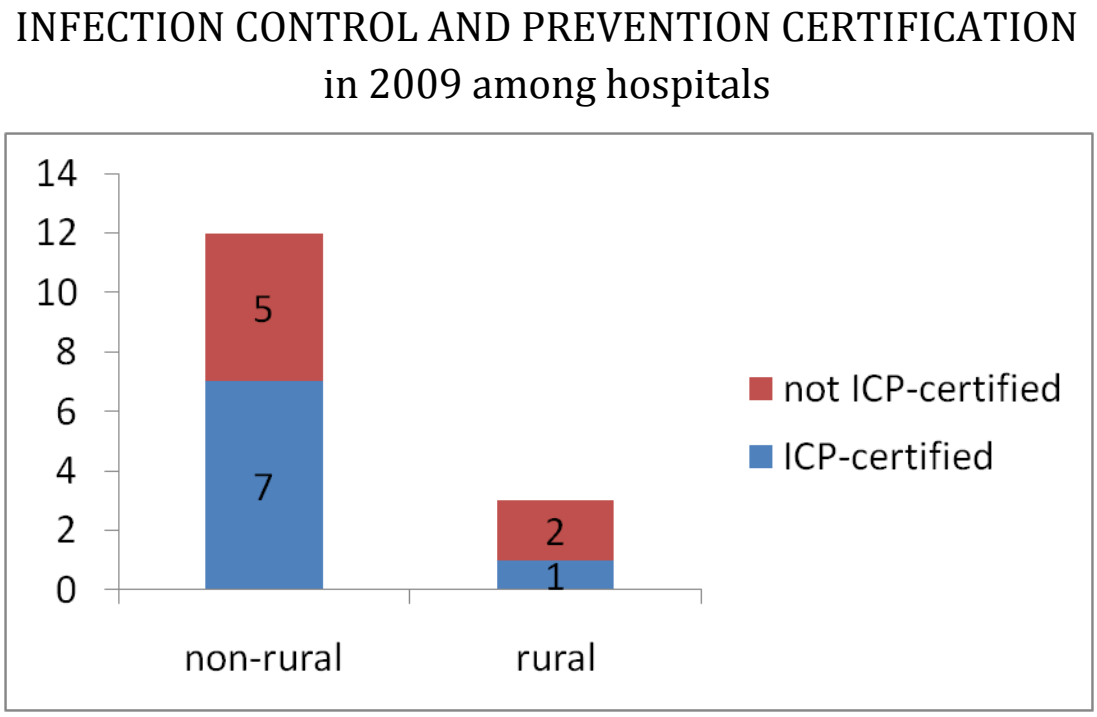

Figure 32

Except for 1 rural hospital that was in the process of developing their infection control surveillance system, all surveyed healthcare facilities (about 94%) had already developed their in-house systems to track the occurrence of post-procedural infection.

All surveyed facilities reported using CDC infection control guidelines, and most of the facilities partially relied on the Occupational Safety and Health Administration (OSHA) and the Association for Professionals in Infection Control and Epidemiology (APIC) recommendations to detect and track HAIs. In addition to the guidelines published by CDC, OSHA, and APIC, healthcare facilities used a mix of multiple national infection control standards and guidelines such as those published by the Association of Perioperative Registered Nurses (AORN) and the Society of Gastroenterology Nurses and Associates (SGNA) standards to develop their internal policies and procedures to prevent HAIs. Figure 33 below shows the number of facilities and the guidelines/standards used.

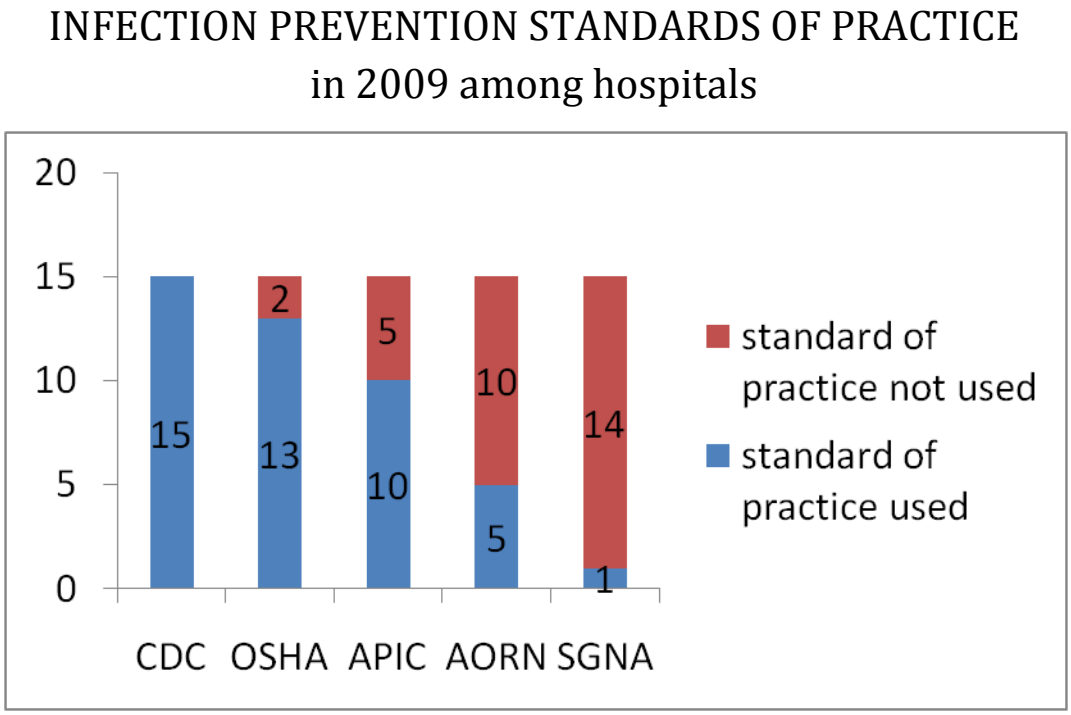

Figure 33

Tracking Healthcare-Associated Infections

All surveyed facilities reported having the list of communicable diseases and conditions that require notification to the NSHD's Office of Epidemiology. However, it is noteworthy to mention that only a small fraction of HAIs and facility outbreaks were reported to NSHD directly from healthcare facilities. Most of the HAIs and outbreaks are detected through a very effective laboratory reporting system to NSHD.

Data gathered from the survey showed that despite having systems to identify and track HAIs only 60% of the surveyed facilities had the capability of tracking bloodstream infections. Overall, 86% of the facilities were able to track urinary tract infection and 54% were able to track surgical site infections. All surveyed facilities reported being able to detect communicable diseases present at the time of a patient's admission as well as having in place a policy to identify staff and employees who contract HAIs. Furthermore, all surveyed hospitals reported incorporating infection control surveillance and prevention activities in their standard quality assurance practices as illustrated in Figure 34. However, it is unclear from the survey data which hospitals are regularly applying the concepts of isolation for those already infected and are quarantining their immediate contacts. Additionally, it is unknown whether healthcare facilities are appropriately restricting staff who contract infectious diseases from continuing to work so as to limit the spread of infection within the facility.

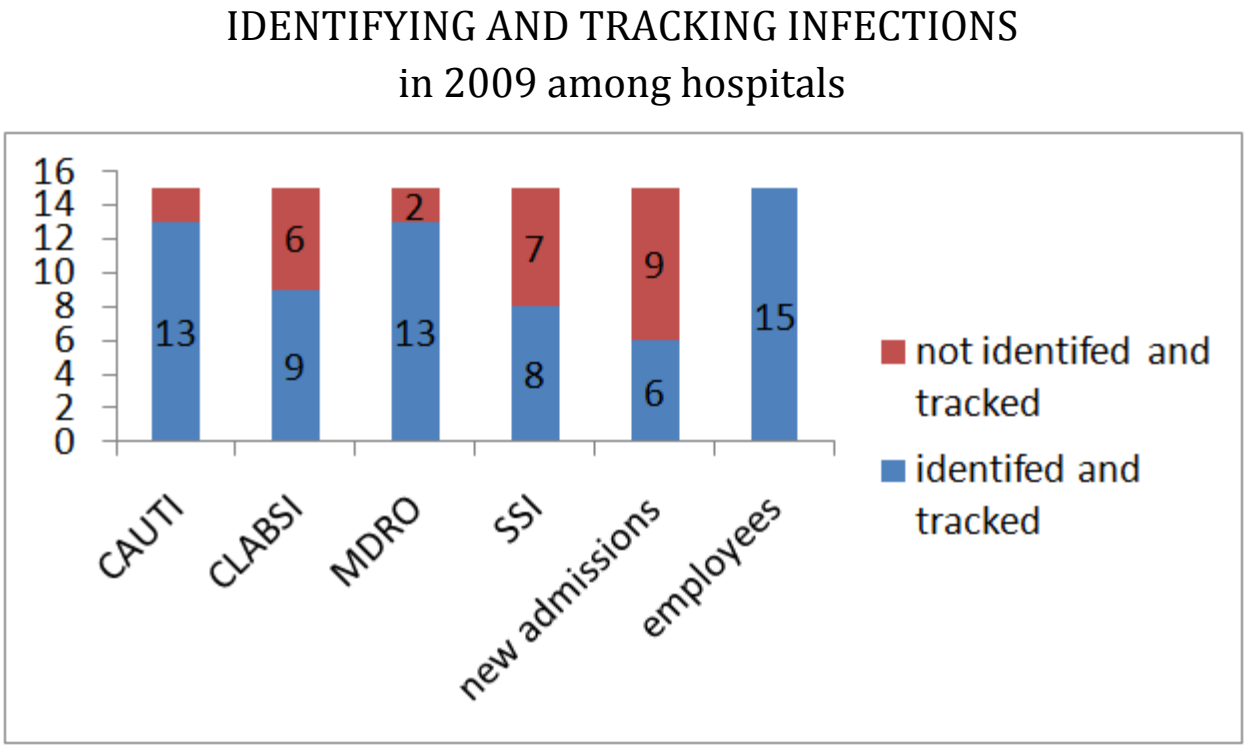

Figure 34

Hand Hygiene

Hospital staff used gloves in all surveyed hospitals for procedures involving a contact with body fluids and before handling potentially contaminated surfaces or equipment. Additionally healthcare staff performed proper hand hygiene after a contact with potentially contaminated surfaces. Although soap and water were easily accessible in every inspected facility, it was observed that staff performed proper hand hygiene before or after patient contact in 14 out of 15 surveyed facilities. More concerning was the observation that only in 7 out of 15 surveyed hospitals surgical teams performed proper surgical scrub, as illustrated in Figure 35. NSHD provided strong and immediate recommendations to enforce proper hand hygiene and environmental decontamination in all healthcare facilities licensed by the state.

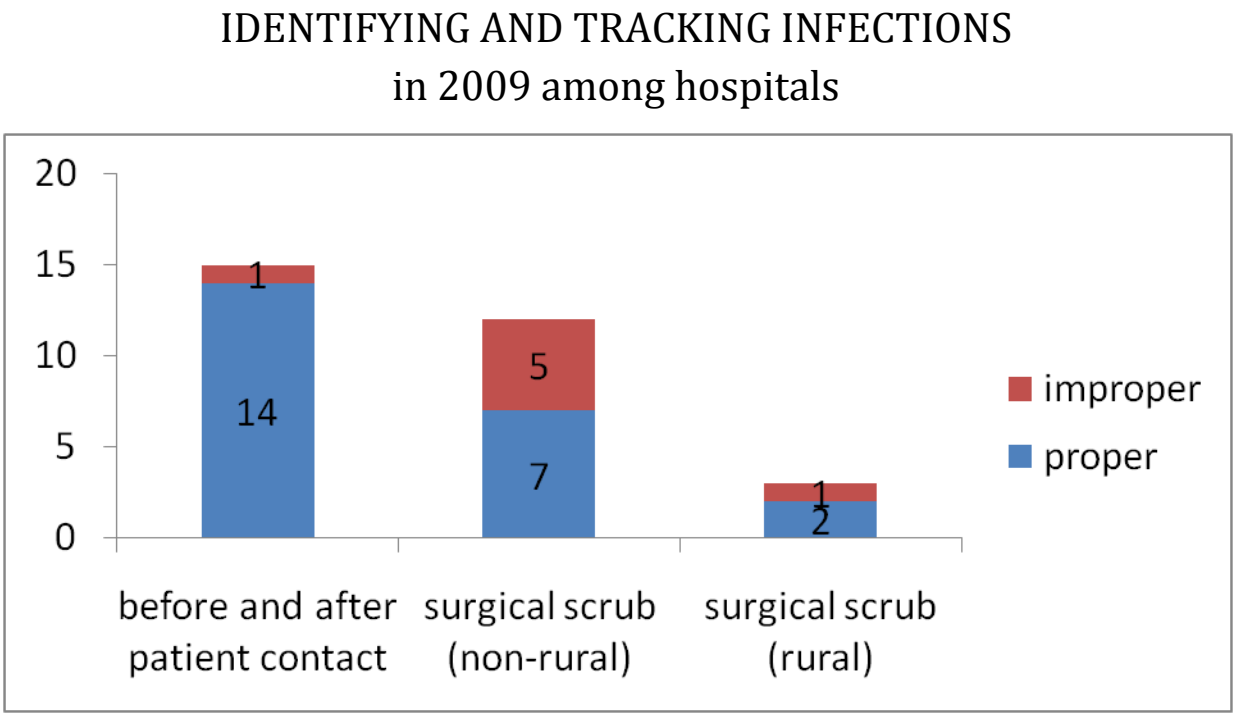

Figure 35

Safe Injection Practices

Based on the survey findings, all surveyed facilities practice proper and safe injection practices in regards to using one needle, one syringe, and one single dose of medication vial per patient. Additionally all surveyed facilities properly discard used needles, syringes, and open medication vials as recommended by the manufacturers. Most of the surveyed facilities used multi-dose medication vials. However, when it came to the proper opening, labeling, and storing of used medication vials, 1 of the urban hospitals did not properly record the date of opened multi-dose medication vials. Failure to record the date a medication is opened may result in an expired medication being used to treat a patient, which would put the patient at risk, whether from potential side effects or ineffective treatment.

Disinfection and Sterilization

The 8 healthcare facilities that performed on-site sterilization procedures reported close adherence to the manufacturer's recommendations to properly sterilize equipment and supplies. These facilities reported having standard procedures to recall inadequately sterilized/processed instruments and tools. Nevertheless, only 75% of those facilities

were found to have adequately trained staff to perform proper sterilization and disinfection. It is important to mention that 25% of these facilities have a contract with the Food and Drug Administration (FDA) that allows for reprocessing single use items. However, it is unknown to what extent such facilities were able to comply with the FDA contract and maintain a high quality of sterilization in their facility.

All the surveyed facilities reported cleaning and disinfecting operation rooms, anesthesia carts, and glucometers after each patient and procedure. Additionally, all surveyed facilities reported complying with the manufacturer's guidelines in order to ensure proper environmental decontamination, disinfection, and sterilization.

Protecting and Immunizing Healthcare Workers

All surveyed facilities reported maintaining a log of needle sticks and sharp injuries among staff and patients in their facility. Additionally, all facilities reported using a log for employee tuberculosis testing. All of the facilities reported offering the hepatitis B vaccine and seasonal influenza shots to their employees. However, the percentage of employees who actually received these vaccines is currently unknown. Nationally, healthcare providers have a relatively low rate of receiving the influenza vaccine.

Lessons Learned and Recommendations

Epidemiology is central to effective surveillance activities and remains so for HAIs. Findings from the infection risk assessment survey tool were directly relevant to Nevada's specific issues and concerns related to controlling and preventing HAIs. Observed trends in Nevada were comparable to findings in other states.

Data collected and knowledge gained through this survey tool will significantly expand the awareness of proper infection prevention and control technique among healthcare facilities. It will elevate the extent to which infection control deficiencies are identified and remedied and will help in preventing future HAIs through the following recommendations:

- Continue to describe and evaluate behavioral patterns in the clinical services and activities that can lead to or may increase the patient's risk for contracting or spreading infections.
- Prioritize the facility inspections and focus the efforts on preventable risk factors that may lead to HAIs.
- Develop curriculum to educate and train infection control nurses and other infection control staff to implement evidence-based interventions and prevent HAIs in their healthcare facilities.
- Develop a multidisciplinary team approach and build state capacity to conduct joint inspections with a major focus on infection prevention.
- Enhance the quality and frequency of facility inspections through using a multidisciplinary teams approach for joint inspections that will focus on infection control.
- Develop and enhance the communication process and collaboration between the Office of Epidemiology and the regulatory agency.
- Develop curriculum for training inspectors in Nevada to identify and evaluate inadequate infection control practices, breaches, and other errors that could be associated with increasing risks for HAIs.
- Provide recommendations for potential needs to re-evaluate or change some clinical practices and protocols in one or more facilities with high rates of HAIs.
- Use findings, conclusions and lessons learned to focus training activities for healthcare providers on the proper prevention of HAIs.

- Develop performance measures, indicators, and benchmarks that could be regularly evaluated to assess progress toward reducing the incidence of HAIs.
- Require all facilities to develop a detailed infection control plan in their facility that would identify how each facility would prevent HAIs and the team who will address this emerging concern.
- Require each healthcare facility/hospital to have at least one full-time licensed infection control specialist.
- Provide comprehensive annual training and regular updates on identifying, reporting, and controlling HAIs.
- Use CDC guidelines to assist each facility in developing standard policy and procedures for preventing HAIs.
- Train providers on the proper use of NHSN.
- Train facility infection preventionists on the proper application of isolation and quarantine as needed.
- Enforce hand hygiene and environmental decontamination.

Future Plans

CDC researchers utilized the Nevada infection risk assessment survey tool to conduct a 3-state pilot study to evaluate the magnitude of the national HAI epidemic. Staff from NSHD, researchers from CDC, and faculty from the University of Nevada are also jointly working on a pilot project to test the value of the survey tool in predicting patterns and identifying modifiable risk factors and determinants of HAIs and outbreaks. Proposed objectives and activities in this project will mostly focus on identifying inappropriate/inadequate behaviors, subtle errors, improper interventions/activities/actions, underlying root causes, or any other risk factors or events that could be associated directly or indirectly with increasing the incidence of HAIs. The prospective of gathering detailed information and analyzing data collected through this innovative study and novel approach is to allow for:

- A complex multi-factorial estimation of the magnitude of the problem of HAIs and risks associated with patients (host), healthcare facilities (environment), miscommunications (systems), and specific behaviors of healthcare providers (knowledge, practice and attitudes) that may increase the incidence of HAIs.
- Better understanding of underlying, isolated, and/or system related, errors.
- Adding more focus and attention to identify and correct systematic failures and errors within healthcare facilities.
- The timely development of appropriate interventions that would address risk factors associated with HAIs and translate into reducing preventable HAIs.

As an incentive for healthcare providers and to partner with healthcare facilities to prevent HAIs, NSHD is planning to fund four proposals submitted by healthcare facilities to develop practical plans and implement evidence-based practices to prevent HAIs. The four proposals will be selected on a competitive basis.

Hospital Inpatient Dataset

Overview

HACs are complications that are unlikely to be a consequence of the natural progression of an underlying illness. Such conditions were not present when the patient was first admitted to the hospital, but they could have reasonably been prevented through proper application of evidence-based hospital care guidelines. Therefore, they are considered to be one of the measures that reflect the quality of care patients receive during hospitalization.

As part of the Deficit Reduction Act of 2005, the Congress required Health and Human Services (HHS) to identify conditions that are high cost, high volume, or both, and those that could have been reasonably avoided or prevented through the application of in-patient care evidence-based guidelines. When presented as secondary diagnoses, such conditions may result in the assignment of a case to a diagnosis-related group (DRG) that has higher a payment. Patient safety experts, CMS and several other healthcare management organizations (HMOs), and insurance companies agree that hospitals should not receive additional payment for cases in which a preventable condition was not present on admission (PoA), and such cases should be paid as though the secondary diagnoses were not present.

This radical change in the CMS reimbursement process may raise the possibility of changes in the medical practice as physicians and other healthcare providers would probably adhere more closely to clinical guidelines. Additionally, it could result in hospitals performing risk assessments to evaluate the condition of patients upon admission and being more proactive in reducing the frequency of HACs and the incidence of HAIs. It is expected that such measures could improve the quality of healthcare, save lives and millions of dollars.

Nationwide and in Nevada HAIs constitute the wide majority of HACs. Infection control specialists/preventionists and other healthcare staff should use this opportunity to improve healthcare quality and reinforce the importance of their vital role in the care quality delivered by their hospital or healthcare facility. It is important for infection preventionists to be familiar with this important new CMS policy, even though the practice of antisepsis and asepsis concepts and the application of universal disinfection and sterilization processes in addition to the day-to-day clinical surveillance will not be affected.

HACs are identified from hospital inpatient datasets, also known as administrative, billing, or discharge data. However, using inpatient data in order to identify HACs has been inadequate. In order to facilitate the process of identifying such conditions, hospitals have begun to include the PoA indicator code for secondary diagnoses. According to recent CMS reports the use of PoA codes may increase the reliability and validity of identifying HAIs and other HACs. HACs identified by CMS include:

1. Foreign Object Retained After Surgery
2. Air Embolism
3. Blood Incompatibility
4. Stage III and IV Pressure Ulcers
5. Falls and Trauma
    - Fractures
    - Dislocations

- Intracranial Injuries
- Crushing Injuries
- Burns
- Electric Shock

6. Manifestations of Poor Glycemic Control
    - Diabetic Ketoacidosis
    - Nonketotic Hyperosmolar Coma
    - Hypoglycemic Coma
    - Secondary Diabetes with Ketoacidosis
    - Secondary Diabetes with Hyperosmolarity
7. Catheter-Associated Urinary Tract Infection
8. Vascular Catheter-Associated Infection
9. Surgical Site Infection Following:
    - Coronary Artery Bypass Graft – Mediastinitis
    - Bariatric Surgery
        - Laparoscopic Gastric Bypass
        - Gastroenterostomy
        - Laparoscopic Gastric Restrictive Surgery
    - Orthopedic Procedures
        - Spine
        - Neck
        - Shoulder
        - Elbow
10. Deep Vein Thrombosis/Pulmonary Embolism
        - Total Knee Replacement
        - Hip Replacement

Hospital-Acquired Conditions

There were 633 HACs identified in Nevada during 2009. Though the focus of NSHD has primarily been on developing a deeper understanding of why they occur, so that effective interventions can be designed to prevent future harm to patients from these preventable health outcomes events. This focus on learning helps to create an environment in which adverse events and their causes are shared to accelerate the pace of change in the pursuit of the safest possible healthcare system.

This section is one of many sources of information now available on healthcare quality and patient safety in Nevada. It is designed to help patients identify safety issues to discuss with their healthcare providers, and to give policy-makers an overview of patient safety activities in the state. However, this report is only one piece of the larger picture of evaluating and improving patient safety and the quality of care in Nevada hospitals. Armed with that information, patients and family members can ask healthcare providers about the efforts and progress done in their facility to prevent HACs from occurring.

The information in this report should be a basis for further learning, rather than just a way to compare facilities based on frequencies of HACs. Patient awareness is a very important tool to improve safety, but it is important to keep these numbers in perspective. The HACs listed on the following page represent a very small fraction of all of the procedures and admissions at Nevada hospitals. Reports could be higher or lower at a specific facility for a variety of reasons. A higher number of reported events do not necessarily mean that a facility is less safe, and a lower numbers do not necessarily mean the facility is more safe. In some cases, the number of events may be higher at facilities that are especially vigilant about identifying such conditions and errors.

This annual report provides an overview of what the most recent year of data can teach us about the risk of HACs and the best approaches for preventing them, with a major focus on the most common types of events such as HAIs, falls, pressure ulcers, wrong-site surgeries or invasive procedures, and retained foreign objects. For each of these categories of events, we will briefly discuss what we have learned, what is being done to prevent them from happening, and how we can continue to move down the path towards creating and sustaining the safest possible healthcare system.

Frequency of Hospital-Acquired Conditions

In 2009, a total of 633 HACs were identified in Nevada. As represented in Table 11 below, five major categories—vascular catheter associated-infections, falls, pressure ulcers, deep venous thrombosis, and catheter-associated urinary tract infections—formed over 90% of these preventable conditions. Comparable to patterns observed in other states and at the national level, the types of events most likely to lead to serious patient harm in Nevada were vascular catheter-associated infections (52.8%); about one in two HACs were due to vascular catheter-associated infections. Falls accounted for more than one in five (16.0%) of all HACs, while stage III and IV pressure ulcers constituted more than 11.4%; deep venous thrombosis were 7.1%, and catheter-associated urinary tract infections accounted for 5.8%. Foreign object retained after surgery and manifestations of poor glycemic control, accounted for 2.7% and 2.2% respectively as illustrated in Figure 36 on the following page.

HOSPITAL-ACQUIRED CONDITIONS
in 2009 among hospitals

how to read this table:

This table shows the number of HACs that occurred in acute, non-specialty, non-critical access hospitals, including a title and frequency for each condition as well as its CMS condition number.

HOSPITAL-ACQUIRED CONDITIONS (January 1, 2009 – December 31, 2009)	633	
condition	**frequency**	**condition number**
foreign object retained after surgery	17	1
air embolism	0	2
blood incompatibility	0	3
stage III and IV pressure ulcers	72	4
falls and trauma	101	5
manifestations of poor glycemic control	14	6
catheter-associated urinary tract infection	37	7
vascular catheter-associated infection	334	8
surgical site infection following coronary artery bypass graft – mediastinitis	1	9A
surgical site infection following bariatric surgery	4	9B
surgical site infection following orthopedic procedures	8	9C
deep vein thrombosis/pulmonary embolism	45	10
total conditions for hospitals	**633**	

Table 11

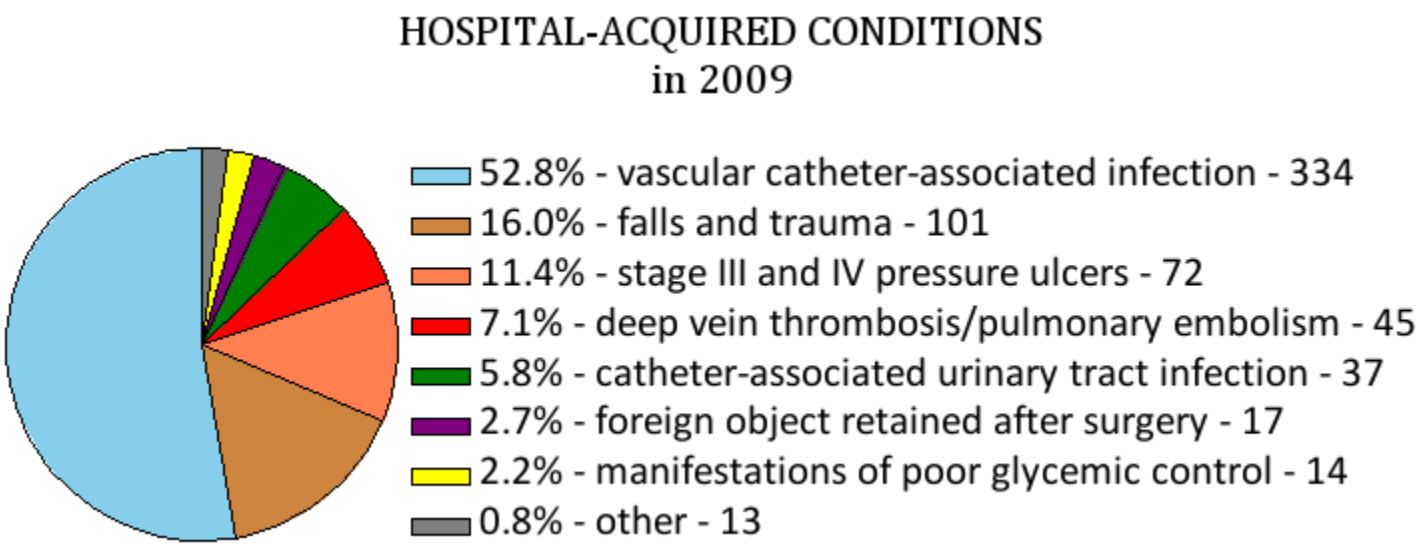

Figure 36

Adverse health events and HACs were reported by hospitals of all sizes, specialties, and locations. Larger hospitals reported more than smaller ones which may simply reflect larger volumes of patients served, though it may also be due to differences in the types of procedures performed and variable patient demographics. For instance, very small hospitals were less likely to perform surgical or other invasive procedures or have many patients with long or more complicated stays.

Root Causes of Hospital-Acquired Conditions

HACs are serious, preventable events. One means of preventing them is to learn from those that occur what went wrong and what actions would be most effective at preventing them in the future. Such an investigation often involves a root cause analysis. This involves a close examination of potential risk factors that might have led to the event. Such factors can include lack of communication, staffing levels, training, equipment malfunctions, failure to follow policies, protocols, and procedures, or confusion about roles and responsibilities.

The process of completing a root cause analysis is a crucial step in determining associations and deficiencies. It is difficult to prevent a recurrence of an event without identifying root causes and risk factors that could have lead to the negative health outcome. It's also important that facilities look at patterns of events and investigate the systems or steps involved in caring for the patient. When multiple similar events persist, analysis of their root causes can reveal patterns of vulnerability that might not be apparent from one event.

Nevada hospitals are encouraged to prevent adverse HACs through improvement in the quality of care they provide their patients. Patient safety goals include improvements in medication use, the elimination of transfusion errors related to patient misidentification, and the implementation of best practices to prevent surgical site infections, central-line associated bloodstream infections, and falls. It is highly recommended that hospitals form a response team representing various disciplines such as medical staff, nursing, infection control and prevention specialists, finance, medical records, quality improvement, patient safety, and risk management. Such teams should assess the effectiveness of the measures taken to identify and prevent HACs. HAIs are very sensitive for quality care improvements within a hospital and could be used as an early and highly sensitive indicator of progress toward eliminating HACs.

Professional education and ongoing updates for healthcare providers is a challenge. It is essential to ensure that clinical departments examine available evidence-based guidelines for the prevention of HACs and implement, to the greatest extent possible, practices and protocols in alignment with the national guidelines. Practices and protocols regarding the insertion, use, and maintenance of vascular catheters are described in the CDC's *2002 Guidelines for the Prevention of Intravascular Catheter-Related Infections*; other effective approaches are published in the scientific literature.

Hospitals should develop and implement protocols for the prevention and treatment of deep-vein thrombosis and pulmonary embolism. Additionally, healthcare facilities should have a prophylaxis protocols in place for surgical patients in accordance with the measures outlined in the *Surgical Care Improvement Project's National Quality Measures*. Such protocols should address individualized risks, potential needs for prophylaxis, and special care during pre and post-operative treatment that may also include safe medication practices for anticoagulation drugs (e.g., the high-alert drug heparin).

Hospitals should reemphasize the importance of following recommended practices to prevent wrong-site surgery and should consider assessing the safety measures in the surgical suite, and continuously work to transform the climate into one preoccupied with patient safety.

By reducing the harm to patients and addressing some of the most common system breakdowns that usually lead to negative health outcomes, hospitals can improve healthcare quality and save money. But despite some progress, opportunities for learning from past errors remain, along with challenges to a consistent and robust implementation of evidence-based best practices.

Plans to Reduce the Frequency of Hospital-Acquired Conditions

Consumers and the general public have the right to access information about the quality of healthcare provided in Nevada hospitals. The 2009 Annual Hospitals Report can help the public to become more informed and make better decisions regarding healthcare choices of hospitals. Additionally, such information can facilitate the discussion between the patient, her/his family, and healthcare providers about specific needs, potential risks, treatment options, and expected outcomes.

Due to differences in the severity of illnesses treated, measuring quality of healthcare is not an exact science and it is still in its early developmental phase. However, NSHD has made every effort to provide the most reliable data for the quality measures currently available for use. While this section of the first hospital report describes frequencies and percentages of HACs, it is our intention for future reports to assess annual trends and evaluate intervention outcomes and comparing baseline data of 2009 with data from subsequent years, especially for HAIs.

Efforts are underway to assist hospitals and other healthcare facilities to systematically address the challenge of HAIs in their institutions. NSHD is currently working on the creation and establishment of four prevention collaborative initiatives in different parts of the state, looking at the identification of best practices to reduce HAIs. NSHD's goal is to reduce the frequency of HACs with a major focus on HAIs. HAIs are among the top causes of unnecessary illness and death in Nevada. Furthermore, they results in extra days of hospitalization and higher healthcare costs. NSHD is taking serious action to eliminate HAIs and all other avoidable HACs. Preventing HACs improves the quality of life for all Nevadans, saves money, and most importantly, saves lives.

NSHD and its community partners intend to use the HAC findings to identify strategies for improving processes of care, with the ultimate goal of preventing all avoidable HACs. NSHD, state partners, and stakeholders will continue to focus on identifying and disseminating information about risks and successful strategies for preventing HACs, and to promote a statewide culture of safety, transparency, accountability and learning.

Through building and sustaining partnerships with Nevada hospitals, and working closely with the Nevada Medicaid administrative data to validate prevalence of certain HACs, NSHD will continue monitoring HAC patterns and trends. Additionally, NSHD is committed to working with healthcare providers to reverse the trends of such negative health outcomes. Data analysis, reports and updates will be available to healthcare facilities, policy-makers, the public and media. Collaborating with state stakeholders and individual facilities will promote consistent interpretation and investigation of HACs and events and the application of best practices.

National Healthcare Safety Network

NHSN is an internet-based surveillance system for healthcare facilities managed by CDC. For more information about NHSN, please visit the following webpage: www.cdc.gov/nhsn/about.html.

In 2009, 8 hospitals in Nevada had enrolled in NHSN, thanks in part to the assistance of HealthInsight, the Quality Improvement Organization for Nevada.

Further information about enrollment counts, legislative developments regarding NHSN, and the formation of an NSHD group within NHSN will be available in the 2010 Annual Hospitals Report. NHSN will improve the quality and scope of healthcare facility surveillance in Nevada and will be prominently featured in future reports.

HOSPITALS

NRS 449.012 defines a hospital as:

> an establishment for the diagnosis, care and treatment of human illness, including care available 24 hours each day from persons licensed to practice professional nursing who are under the direction of a physician, services of a medical laboratory and medical, radiological, dietary and pharmaceutical services.

In 2009, there were 60 hospitals in Nevada. On November 25, 2009, University Medical Center Rancho Rehabilitation Center closed.

NRS 449.021 further classifies hospitals based on 4 categories of service:

- Medical
- Surgical
- Obstetrical
- Psychiatric

Hospitals providing only one or two categories of service are designated as either medical, surgical, obstetrical, psychiatric, or combined-category hospitals. Those providing medical, surgical, and obstetrical services, at a minimum, are designated as general hospitals. Under these criteria, there are 11 possible hospital classifications. In practice, however, only 6 of the 11 were represented by operating hospitals in Nevada in 2009:

- Medical
- Surgical
- Psychiatric
- Medical-Surgical
- Medical-Surgical-Psychiatric
- General

In 2009, there were 15 medical, 1 surgical, 11 psychiatric, 12 medical-surgical, 1 medical-surgical-psychiatric, and 20 general hospitals. Of the 20 general hospitals, 2 also provided psychiatric services. For a complete list of them along with their classifications, see Appendix C.

NRS 449.0177 defines a rural hospital as:

> a hospital with 85 or fewer beds which is:
>
> - The sole institutional provider of healthcare located within a county whose population is less than 100,000;
> - The sole institutional provider of healthcare located within a city whose population is less than 25,000; or
> - Maintained and governed pursuant to NRS 450.550 to 450.750, inclusive.

In 2009, there were 15 rural hospitals. For a complete list of them, see Appendix D.

Banner Churchill Community Hospital

address:
801 E Williams Ave
Fallon NV 89406

phone number:
775-423-3151

website:
www.bannerhealth.com/locations/nevada/banner+churchill+community+hospital/_banner-churchill-community-hospital.htm

accreditation:
The Joint Commission

bed count:
40

date of last inspection:
June 24, 2009

categories of services provided:

medical | surgical | obstetrical | acute, non-critical access

services provided:

- ambulance services (owned)
- anesthesia
- blood bank
- chemotherapy service
- CT scanner
- dietetic service
- emergency department (dedicated)
- emergency services
- ICU – cardiac (non-surgical)
- ICU – medical/surgical
- ICU – neonatal
- ICU – pediatric
- ICU – surgical
- laboratory – clinical
- magnetic resonance imaging
- nuclear medicine
- obstetric service
- occupational therapy services
- operating rooms
- orthopedic surgery
- outpatient services
- pharmacy
- physical therapy services
- post-operative recovery rooms
- radiology services – diagnostic
- respiratory care services
- rehab – inpatient (non-CARF)
- rehab – outpatient
- social services
- speech pathology services
- surgical services – inpatient
- surgical services – outpatient

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Banner Churchill Community Hospital, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	1 total inspection	
deficiency	**frequency**	**regulation**
appropriate care of patient	1	NAC 449.3622
construction standards	1	NAC 449.3154
delivery rooms	1	NAC 449.3645
dietary services	1	NAC 449.338
emergency services	1	NAC 449.331
emergency services	2	NAC 449.349
infections and communicable diseases	2	NAC 449.325
intensive care services	2	NAC 449.371
medication orders	2	NAC 449.343
nursing services	1	NAC 449.361
obstetrical services	1	NAC 449.364
quality of care/policies procedures	1	NAC 449.314
rehabilitative services	1	NAC 449.346
respiratory care services	1	NAC 449.389
social services	3	NAC 449.352
sterile supplies and medical equipment	1	NAC 449.327
surgical services	1	NAC 449.385
transfer agreements	1	NAC 449.331
total deficiencies for this facility	**24**	

how to read this table:

This table shows the number of complaints received against Banner Churchill Community Hospital, including state or federal regulation status and whether they were substantiated. No action was necessary for the 1 other complaint.

COMPLAINTS (January 1, 2009 – December 31, 2009)	2 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	0	1	1
federal	0	0	0
total complaints for this facility	**0**	**1**	**1**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Banner Churchill Community Hospital, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	0 substantiated allegations	
allegation category	**sub-description**	**frequency**
total substantiated allegations for this facility		**0**

how to read this table:

This table shows the number of HACs that occurred at Banner Churchill Community Hospital, including a title and frequency for each condition as well as its CMS condition number.

HOSPITAL-ACQUIRED CONDITIONS (January 1, 2009 – December 31, 2009)	3 total HACs	
condition	**frequency**	**condition number**
foreign object retained after surgery	0	1
air embolism	0	2
blood incompatibility	0	3
stage III and IV pressure ulcers	0	4
falls and trauma	2	5
manifestations of poor glycemic control	0	6
catheter-associated urinary tract infection	1	7
vascular catheter-associated infection	0	8
surgical site infection following coronary artery bypass graft – mediastinitis	0	9A
surgical site infection following bariatric surgery	0	9B
surgical site infection following orthopedic procedures	0	9C
deep vein thrombosis/pulmonary embolism	0	10
total conditions for this facility	**3**	

Banner Churchill Community Hospital's Response to the 2009 Annual Hospitals Report

Banner Churchill Community Hospital recognizes the importance of providing safe, quality health care in an environment that promotes accountability and transparency. The following demonstrates opportunities to reinforce our existing internal processes based upon nationally recognized guidelines and evidence-based practice.

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

Priority areas for short-term and long-term improvement for Banner Churchill Community Hospital are falls and healthcare-associated infections, in particular, urinary tract and central line infections.

2A: What is the short-term improvement plan (next 12 months)?

Short-term improvement plans are to participate in the National Database of Nursing Quality Indicators (NDNQI) which includes falls, restraints, pressure ulcers, catheter-associated urinary tract infections, ventilator-associated pneumonias, and central line-associated blood stream infections. Banner Health Care also requires participation in their safety and quality strategic initiatives which include all CMS Core Measures and Patient Safety Indicators, including AMI, Pneumonia, Heart Failure, Surgical Care Improvement Project, Pediatric Asthma and Readmission Rates as well as reduction in variation in pneumonia care practices and utilization of sepsis and central line bundles to decrease infections. Additionally, in 2011, Banner Churchill as part of Banner Health Care is participating in National Healthcare Safety Network (NHSN) which is the national benchmarking organization for healthcare-associated infections. This will allow us to fully align our surveillance methods and allow us to accurately benchmark our performance.

Computer physician order entry will also be implemented in July, 2011 to enhance patient safety related to physician orders.

2B: How will the organization measure success?

Success will be measured for the NDNQI indicators by utilizing the comparative hospitals' median score and being lower than the median for all indicators. The CMS Core Measures and Patient Safety Indicators will be measured by being at or above the established Banner Health targets which are AMI-98.8%, Pneumonia-96.6%, Heart Failure-97.3%, Surgical Care Improvement Project-97.0%, Pediatric Asthma-95.0%, and Readmission Rates-TBD. For the reduction in variation of pneumonia care practices the target is a 55.5% reduction in 2011 and the utilization of the bundles is TBD. All targets are in the top quartile nationally.

3A: What is the long-term improvement plan (next 2-4 years)?

Long-term improvement plans will be to continue with NDNQI, NHSN, and the Strategic Initiatives as determined by Banner Health and CMS. Banner Health re-establishes its initiatives annually to ensure that all CMS measures are implemented and monitored as well as other evidence-based bundles and initiatives to improve patient care quality and safety.

3B: How will the organization measure success?

Success will be measured by achieving the top decile for all measures as evidence by meeting or exceeding of the established targets which are increased each year. The goal at Banner Health is to be in the top decile for all measures by 2015. Success for NDNQI will be to remain below the comparative hospitals median and to achieve no falls, pressure ulcers, hospital-acquired infections, etc.

In 2012, Positive Patient Identification will be implemented in for the form of bedside bar-coding for medications.

4: Please give a statement of commitment:

Banner Churchill Community Hospital as part of the Banner Health System is committed to making a difference in people's lives through excellent patient care. Our vision is to be a national leader recognized for clinical excellence and innovation, preferred for a highly coordinated patient experience, and distinguished by the quality of our people.

Battle Mountain General Hospital

address:
535 S Humboldt St
Battle Mountain NV 89820

phone number:
775-635-2550

website:
www.bmgh.org

certification:
CMS certified

bed count:
25

date of last inspection:
November 10, 2008

categories of services provided:

medical

services provided:

- blood bank
- CT scanner
- dietetic service
- emergency department (dedicated)
- emergency services
- laboratory – anatomical
- laboratory – clinical
- long term care (swing-beds)
- magnetic resonance imaging
- organ transplant services
- outpatient services
- pharmacy
- physical therapy services
- psychiatric – geriatric
- radiology services – diagnostic
- respiratory care services
- social services
- speech pathology services

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Battle Mountain General Hospital, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	0 total inspections	
deficiency	**frequency**	**regulation**
total deficiencies for this facility	**0**	

how to read this table:

This table shows the number of complaints received against Battle Mountain General Hospital, including state or federal regulation status and whether they were substantiated.

COMPLAINTS (January 1, 2009 – December 31, 2009)	0 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	0	0	0
federal	0	0	0
total complaints for this facility	**0**	**0**	**0**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Battle Mountain General Hospital, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	0 substantiated allegations	
allegation category	**sub-description**	**frequency**
total substantiated allegations for this facility		**0**

BHC West Hills Hospital

address:
1240 E 9th St
Reno NV 89512

phone number:
775-323-0478

website:
www.psysolutions.com/facilities/westhills/

accreditation:
The Joint Commission

bed count:
95

date of last inspection:
October 1, 2009

categories of services provided:

psychiatric

services provided:

- alcohol and/or drug services
- psychiatric – child/adolescent
- psychiatric – geriatric
- psychiatric – inpatient
- psychiatric – outpatient

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at BHC West Hills Hospital, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	14 total inspections	
deficiency	**frequency**	**regulation**
administration of drugs	1	482.23(c)
appropriate care of patient	2	NAC 449.3622
assessment of patients	1	NAC 449.3624
chief executive officer	2	482.12(b)
discharge planning	2	NAC 449.332
discharge planning needs assessment	2	482.43(b)(1)
emergency preparedness	1	NAC 449.316
governing body	4	482.12
governing body	2	NAC 449.313
infection control officer(s)	1	482.42(a)
maintenance of physical plant	2	482.41(a)
medical staff – accountability	1	482.12(a)(5)
medical staff responsibilities	1	482.22(c)(5)
nursing services	1	482.23
nursing services	2	NAC 449.361
nutritional status of patients	1	NAC 449.339
patient rights	4	482.13
patient rights: care in safe setting	4	482.13(c)(2)
patient rights: grievances	2	482.13(a)(2)
patient rights: informed consent	5	482.13(b)(2)
physical environment	1	482.41
physical environment	4	NAC 449.316
policies for laboratory services	1	482.27(a)(4)
QAPI	1	482.21
QAPI feedback and learning	1	482.21(c)(2)
QAPI improvement activities	1	482.21(c)(2)
qualified dietitian	3	482.28(a)(2)
quality improvement	1	NAC 449.3152
quality of care/staffing	1	NAC 449.314
rights of patient	2	NAC 449.3626
RN supervision of nursing care	2	482.23(b)(3)
staffing and delivery of care	1	482.23(b)
supervision of contract staff	1	482.23(b)(6)
total deficiencies for this facility	**61**	

how to read this table:

This table shows the number of complaints received against BHC West Hills Hospital, including state or federal regulation status and whether they were substantiated. Of the 2 other complaints, no action was necessary for 1, and 1 is under administrative/off-site investigation.

COMPLAINTS (January 1, 2009 – December 31, 2009)	25 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	5	13	2
federal	3	2	0
total complaints for this facility	**8**	**15**	**2**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against BHC West Hills Hospital, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	9 substantiated allegations	
allegation category	**sub-description**	**frequency**
accidents	protective supervision	2
admission, transfer and discharge rights		1
death – general		1
quality of care/treatment		1
quality of care/treatment	care/service not received per physician's orders	1
resident/patient/client abuse	resident to resident	1
resident/patient/client neglect	other	2
total substantiated allegations for this facility		**9**

BHC West Hills Hospital's Response to the 2009 Annual Hospitals Report

In response to the following questions, we recognize the importance of providing safe, quality health care in a culture that promotes accountability and transparency and will use the following as an opportunity to reinforce our existing internal processes based upon nationally recognized guidelines as referenced below.

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

Based on the 2009 Nevada Hospital Report findings for West Hills Hospital and the organization's priorities, the hospital has identified priority areas in accordance with regulatory requirements and standards.

2A: What is the short-term improvement plan (next 12 months)?

West Hills Hospital is dedicated to providing ethical, compassionate, and therapeutic mental health services which enhance health, self-esteem, and quality of life. We are committed to sustaining a safe, supportive environment where patients, their families, mental health professionals, and employees are treated with dignity and respect. West Hills Hospital strives for excellence and maintains fiscal responsibility while serving the community and fostering personal and professional growth.

2B: How will the organization measure success?

West Hills Hospital will monitor progress and measure success according to regulatory standards, requirements and guidelines.

3A: What is the long-term improvement plan (next 2-4 years)?

West Hills Hospital is committed to the provision of ethical, compassionate and therapeutic mental health services, provided in a safe, supportive environment, using the regulatory standards, requirements and guidelines outlined by The Joint Commission, State of Nevada, and Centers for Medicare and Medicaid.

3B: How will the organization measure success?

West Hills Hospital will monitor progress and measure success according to aforementioned regulatory standards, requirements and guidelines.

4: Please give a statement of commitment:

West Hills Hospital is dedicated and committed to providing ethical, compassionate, and therapeutic mental health services which enhance health, self-esteem, and quality of life. We are committed to sustaining a safe, supportive environment where patients, their families, mental health professionals, and employees are treated with dignity and respect. West Hills Hospital strives for excellence and maintains fiscal responsibility while serving the community and fostering personal and professional growth. To that end, we are committed to monitoring our progress and measure our success based on the regulatory standards, requirements and guidelines outlined by The Joint Commission, State of Nevada, and Centers for Medicare and Medicaid.

Boulder City Hospital

address:
901 Adams Blvd
Boulder City NV 89005

phone number:
702-293-4111

website:
www.bouldercityhospital.org

certification:
CMS certified

bed count:
67

date of last inspection:
July 28, 2009

categories of services provided:


medical


surgical

services provided:

- anesthesia
- CT scanner
- dietetic service
- emergency department (dedicated)
- emergency services
- home health services
- ICU – medical/surgical
- laboratory – anatomical
- laboratory – clinical
- magnetic resonance imaging
- nuclear medicine services
- occupational therapy service
- operating rooms
- opthalmic surgery
- orthopedic surgery
- outpatient services
- pharmacy
- physical therapy services
- post-operative recovery rooms
- psychiatric – outpatient
- radiology services – diagnostic
- respiratory care services
- social services
- speech pathology services
- surgical services – inpatient
- surgical services – outpatient

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Boulder City Hospital, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	2 total inspections	
deficiency	**frequency**	**regulation**
appropriate care of patient	1	NAC 449.3622
assessment of patients	1	NAC 449.3624
maintenance	1	485.623(b)(4)
nursing services	1	NAC 449.361
nursing services	1	485.635(d)(3)
records systems	1	485.638(a)(4)(ii)
social services	2	NAC 449.352
total deficiencies for this facility	**8**	

how to read this table:

This table shows the number of complaints received against Boulder City Hospital, including state or federal regulation status and whether they were substantiated.

COMPLAINTS (January 1, 2009 – December 31, 2009)	1 total complaint		
complaint	**substantiated**	**unsubstantiated**	**other**
state	1	0	0
federal	0	0	0
total complaints for this facility	**1**	**0**	**0**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Boulder City Hospital, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	3 substantiated allegations	
allegation category	**sub-description**	**frequency**
quality of care/treatment	physician not notified of resident change in condition	1
resident/patient/client assessment		1
resident/patient/client neglect	assess/monitor	1
total substantiated allegations for this facility		**3**

Boulder City Hospital's Response to the 2009 Annual Hospitals Report

Boulder City Hospital (BCH) welcomes the opportunity to relate with integrity and transparency our plans to improve patient safety and quality of care.

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

Based on the 2009 Nevada Hospital Report finding for hospitals and your organization, identify priority areas (i.e., healthcare-associated infections) for short-term and long-term improvement for your organization:

2A: What is the short-term improvement plan (next 12 months)?

- Based upon survey findings and feedback, BCH revised Policies and Procedures to reflect more specific guidance with regard to execution of physician orders, evaluating and meeting the psych/social needs of the patient. Then the team was educated to these changes to promote consistent interventions and documentation of those interventions. The National Patient Safety Goal (NPSG), to improve the effectiveness of communication among caregivers, is a goal that has been shared throughout the organization.
- Educate staff regarding healthcare-associated infections (HAI) and their role in the prevention of HAI through incorporation of evidence-based best practices from sources such as the Centers for Disease Control, National Healthcare Safety Network (NHSN), HealthInsight, Associated Practitioners of Infection Control (APIC), Institute for Healthcare Improvement (IHI), and Southern Nevada Health District (SNHD).
- Monitor incidence of HAI based upon catheter-associated urinary tract infection (CAUTI), central line-associated blood stream infection (CLABSI), ventilator-associated pneumonia (VAP) definitions.
- Direct surveillance of Infection Control practices promoting reduction of HAI reporting results to the Quality and Safety Committees while providing feedback to the employees to reinforce safe practice.

2B: How will the organization measure success?

1. BCH monitors patient satisfaction and documentation monthly and reports this information quarterly to the Quality Improvement and Safety Committees as appropriate. Subsequent surveys have found the areas of deficiency in compliance and no events of similar concern have been identified.
2. BCH tracks and trends HAI incidence quarterly, comparing internal year-to-year outcomes with comparative review of statistics available for similar Critical Access Hospitals from sources such as the CDC benchmarks.

3A: What is the long-term improvement plan (next 2-4 years)?

1. Educational offering for clinical staff to discuss meeting the psych/social needs of the patient was held and well attended. Patient Rights and Patient Satisfaction remain in the forefront of the organization's Safety and Quality decision-making. Physician-approved standing orders have been implemented when appropriative to facilitate consistent interventions.
2. An annual Learning Needs Assessment for employees is performed and an educational calendar is created based on this employee feedback, identified educational needs from survey findings, incident investigations and trends in healthcare. Education promoting effective communication, consistent best practice and holistic care continues to support the caring culture of BCH which emphasizes Safety and Quality as the impetus for all of our actions.
3. BCH adheres to the annual NPSG for Critical Access Hospitals. Quality and Safety reporting will continue to monitor these efforts as well as incorporating recommendations from the Bureau of Healthcare Quality and Compliance surveyors and the Infection Prevention Initiative. The goal is improved hand washing / sanitization throughout the organization.

3B: How will the organization measure success?

1. NPSG # 2 Improve the effectiveness of communication among caregivers will be measured through analysis of concerns to determine if communication is the root cause. NPSG # 7 Reduce the risk of HAI will be measured by comparative data quarterly and annually of the incidence of the aforementioned HAI. A trend of reduced—with the goal of elimination of HAI—negative environmental bio cultures and no outbreak of infection within the organization are key indicators of sustained improvement.
2. BCH received the Loss Control Excellence Award for Safety in December 2010. The facility will be resurveyed in 2013 for this coveted award.

4: Please give a statement of commitment:

BCH will promote, monitor, reinforce and reward safe practices that result in effective communication and the reduction ultimately leading to the elimination of HAI.

Carson Tahoe Regional Medical Center

address:
1600 Medical Pkwy
Carson City NV 89703

phone number:
775-445-8000

website:
www.carsontahoe.com

accreditation:
The Joint Commission

bed count:
172

date of last inspection:
November 12, 2009

categories of services provided:


medical


surgical


obstetrical


psychiatric


acute, non-critical access

services provided:

- alcohol and/or drug services
- anesthesia
- cardiac catheterization laboratory
- cardiac – thoracic surgery
- chemotherapy service
- CT scanner
- dietetic service
- emergency department (dedicated)
- emergency services
- gerontological specialty services
- ICU – cardiac (non-surgical)
- ICU – medical/surgical
- ICU – surgical
- laboratory – anatomical
- laboratory – clinical
- long term care (swing-beds)
- magnetic resonance imaging
- neurosurgical services
- nuclear medicine services
- obstetric service
- occupational therapy service
- operating rooms
- organ transplant services
- orthopedic surgery
- outpatient services
- pediatric services
- pharmacy
- physical therapy services
- positron emission tomography
- post-operative recovery rooms
- psychiatric services – emergency
- psychiatric – child/adolescent
- psychiatric – geriatric
- psychiatric – inpatient
- psychiatric – outpatient
- radiology services – diagnostic
- reconstructive services
- respiratory care services
- rehab – inpatient (CARF acc)
- rehab – inpatient (non-CARF)
- rehab – outpatient
- renal dialysis (acute inpatient)
- social services
- speech pathology services
- surgical services – inpatient
- surgical services – outpatient
- urgent care center services

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Carson Tahoe Regional Medical Center, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	17 total inspections	
deficiency	**frequency**	**regulation**
adequate respiratory care staffing	1	482.57(a)(2)
appropriate care of patient	1	NAC 449.3622
compliance with construction standards	1	NAC 449.3156
construction standards	1	NAC 449.3154
director of respiratory services	1	482.57(a)(1)
discharge planning	1	NAC 449.332
infection control officer responsibilities	1	482.42(a)(1)
infections and communicable diseases	1	NAC 449.325
life safety code standard	2	NFPA 101
nursing care plan	1	482.23(b)(4)
operating room policies	2	482.51(b)
patient rights	1	482.13
patient rights: admission status notification	1	482.13(b)(4)
patient rights: care in safe setting	1	482.13(c)(2)
patient rights: free from abuse/harassment	1	482.13(c)(3)
patient rights: notice of grievance decision	1	482.13(a)(2)(iii)
patient rights: restraint or seclusion	1	482.13(e)(10)
patient rights: restraint or seclusion	1	482.13(e)(11)
patient rights: restraint or seclusion	1	482.13(e)(2)
patient rights: restraint or seclusion	1	482.13(e)(3)
patient rights: restraint or seclusion	1	482.13(e)(4)(i)
patient rights: restraint or seclusion	1	482.13(e)(4)(ii)
patient rights: restraint or seclusion	1	482.13(e)(5)
patient rights: review of grievances	1	482.13(a)(2)
radiologist responsibilities	1	482.26(c)(1)
respiratory care services policies	1	482.57(b)
RN supervision of nursing care	1	482.23(b)(3)
unusable drugs not used	1	482.25(b)(3)
total deficiencies for this facility	**30**	

how to read this table:

This table shows the number of complaints received against Carson Tahoe Regional Medical Center, including state or federal regulation status and whether they were substantiated.

COMPLAINTS (January 1, 2009 – December 31, 2009)	10 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	6	4	0
federal	0	0	0
total complaints for this facility	**6**	**4**	**0**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Carson Tahoe Regional Medical Center, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	6 substantiated allegations	
allegation category	**sub-description**	**frequency**
admission, transfer and discharge rights		2
infection control		1
other services		1
quality of care/treatment		1
resident/patient/client neglect	other	1
total substantiated allegations for this facility		**6**

how to read this table:

This table shows the number of HACs that occurred at Carson Tahoe Regional Medical Center, including a title and frequency for each condition as well as its CMS condition number.

HOSPITAL-ACQUIRED CONDITIONS (January 1, 2009 – December 31, 2009)	16 total HACs	
condition	**frequency**	**condition number**
foreign object retained after surgery	0	1
air embolism	0	2
blood incompatibility	0	3
stage III and IV pressure ulcers	3	4
falls and trauma	6	5
manifestations of poor glycemic control	1	6
catheter-associated urinary tract infection	0	7
vascular catheter-associated infection	4	8
surgical site infection following coronary artery bypass graft – mediastinitis	0	9A
surgical site infection following bariatric surgery	0	9B
surgical site infection following orthopedic procedures	0	9C
deep vein thrombosis/pulmonary embolism	2	10
total conditions for this facility	**16**	

Carson Tahoe Regional Medical Center's Response to the 2009 Annual Hospitals Report

Carson Tahoe Regional Healthcare supports accountable transparency for the improvement and sustainability of safe, quality health care. Based on nationally recognized guidelines, Carson Tahoe Regional Healthcare offers the following as an opportunity to emphasize our existing internal processes:

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

2A: What is the short-term improvement plan (next 12 months)?

1) Patient fall 12 month goal: Improve unit specific fall data transparency for focused improvement of fall prevalence below benchmark standards
   a) Research best practices for latest benchmarking parameters to include patient mix stratification and facility size
   b) Improvement project through Nursing Quality Committee to collect fall prevalence per unit and by injury severity as opposed to overall number of falls

(Reference: Former National Patient Safety Goal, Joint Commission Provision of Care .01.02.08)

2) Infection control 12-month goals:
   a) Reduce/stabilize the number of Clostridium difficile occurrences/10,000 patient days
      - Research disinfectant products for sporocidal disinfectant specific product to destroy Clostridium difficile spores that cause further infection prevalence
   b) Reduce the number of urinary catheter utilization days/1,000 patient days
      - Every 24-hour Foley catheter sticker order for LIP completion to continue urinary catheter or remove
      - Ongoing Professional Practice Evaluation compliance with Surgical Care Improvement Project SCIP-9 initiative performance to ensure urinary catheters are removed by #2 POD
   c) Maintain sterility during central line placement
      - Use of Central Line Bundle initiative for compliance

(Reference: Occupational Safety and Health Administration, 2010 National Patient Safety Goal 7, Joint Commission; Centers for Disease Control, Guideline For Prevention of Catheter-Associated Urinary Tract Infections, 2009; Centers for Disease Control and Prevention Guidelines for the Prevention of Intravascular Catheter Related Infections, 2005; National Institute of Health Save 1,000,00 Lives Campaign, APIC "Guide to Elimination of MRSA Transmission in Hospital Settings, 2010; APIC "Guide to the Elimination of Clostridium difficile in Healthcare Settings, 2008; National Hospital Surveillance Network Report: Data Summary for 2006-2008, December 2009)

3) Deep vein thrombosis/pulmonary embolism goal: Reduce the prevalence of DVT/PE for certain orthopedic cases-hip/knee
   a) Adopt DVT Protocol house wide to assess/treat patients at risk for DVT/PE
   b) Ongoing Professional Practice Evaluation compliance with Surgical Care Improvement Project VTE-1 for hip/knee joint replacement initiative performance to ensure appropriate prophylaxis is provided

(Reference: Center for Medicare & Medicaid, Joint Commission, HealthInsight endorsed Surgical Care Improvement Project)

2B: How will the organization measure success?

1) Patient falls-12-month goal:
   a) Unit trending of patient falls completed monthly
   b) Further monthly trending stratified by no injury-minor category, and moderate-severe-death category
   c) Action plan development for those units with moderate-severe-death fall severity above researched benchmark in any one of 4 quarters

(Reference: Plan, Do, Check, Act process improvement methodology used by Certified Healthcare Quality Professionals)

2) Infection control 12-month goals:
   a) C. difficile
      - Action plan for >5 occurrences/10,000 patient days from monthly compiled data
   b) urinary catheter utilization
      - Monthly tracking to determine reduced number of catheter days by 20% from present utilization baseline
      - Ongoing Professional Practice Evaluation physician compliance for SCIP-9 >/= national benchmark of 89% for all SCIP qualifying cases by year end 2011
   c) central line insertion sterility
      - Monthly audits of Central Line Bundle for a monthly compliance of >90%
      - Tracking by practitioner, any central line with infection within 3 days of insertion

(Reference: Nevada Hospital Surveillance Network Data Summary for 2006-2008, December 2009)

3) DVT/PE 12 month goals:
   a) Monthly trending report audit for 20% DVT Protocol usage by 3rd quarter 2011
   b) Ongoing Professional Practice Evaluation Surgical Care Improvement VTE-1 compliance of 94% or > for all hip/knee joint replacement cases

(Reference: Plan, Do, Check, Act process improvement methodology used by Certified Healthcare Quality Professionals)

3A: What is the long-term improvement plan (next 2-4 years)?

1) Patient fall 2-4-year goal: Continued focused improvement by unit specific data to sustain fall prevalence at/below benchmark standards for all reporting months

2) Infection control 2-4-year goals:
   a) Sustain C. difficile prevalence to <5/10,000 patient days
   b) Further decrease/sustained urinary catheter utilization/1000 patient days to 50% reduction from 2011 baseline
   c) Sustain/improve Central Line Bundle compliance to 98% Bundle compliance for all reporting months

3) DVT/PE 2-4 year goals:
   a) Increased/sustained DVT Protocol usage to 50% from 2011 baseline usage for all reporting months
   b) Sustained Surgical Care Improvement Project VTE-1 initiative compliance to > national benchmark of 94%

3B: How will the organization measure success?

Measurement of the above 2-4-year goals will be the same measurement methodologies as for the 12-month measurement and/or new measurement methodologies will be devised dependent on performance.

(Reference: Plan, Do, Check, Act process improvement methodology used by Certified Healthcare Quality Professionals)

4: Please give a statement of commitment:

Exceed expectations and anticipate the needs of patients while enhancing the quality of care and the quality of the work environment.

(Reference: Agency for Healthcare Research and Quality's measurable quality initiatives to gauge improvement)

Carson Valley Medical Center

address:
1107 US Hwy 395 N
Gardnerville NV 89410

phone number:
775-782-1500

website:
www.cvmchospital.org/

certification:
CMS certified

bed count:
23

date of last inspection:
December 22, 2009

categories of services provided:


medical


surgical

services provided:

- chemotherapy service
- CT scanner
- dietetic service
- emergency department (dedicated)
- ICU – medical/surgical
- laboratory – clinical
- magnetic resonance imaging
- nuclear medicine services
- occupational therapy service
- operating rooms
- orthopedic surgery
- outpatient services
- physical therapy services
- post-operative recovery rooms
- radiology services – diagnostic
- respiratory care services
- rehab – inpatient (non-CARF)
- rehab – outpatient
- speech pathology services
- surgical services – inpatient
- surgical services – outpatient

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Carson Valley Medical Center, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	3 total inspections	
deficiency	**frequency**	**regulation**
appropriate care of patient	1	NAC 449.3622
outpatient services	1	NAC 449.370
quality of care	1	NAC 449.314
total deficiencies for this facility	**3**	

how to read this table:

This table shows the number of complaints received against Carson Valley Medical Center, including state or federal regulation status and whether they were substantiated.

COMPLAINTS (January 1, 2009 – December 31, 2009)	2 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	2	0	0
federal	0	0	0
total complaints for this facility	**2**	**0**	**0**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Carson Valley Medical Center, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	3 substantiated allegations	
allegation category	**sub-description**	**frequency**
physician services	other	1
quality of care/treatment		1
quality of care/treatment	physician not notified of resident change in condition	1
total substantiated allegations for this facility		**3**

Carson Valley Medical Center's Response to the 2009 Annual Hospitals Report

Thank you for the opportunity to respond to the 2009 Nevada Hospital Report. After viewing the report I believe our hospital is on the right track to address the issues identified in the report.

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

Carson Valley Medical Center (CVMC) has been in the process of implementing patient-centered care since October of 2009. The patient-centered care model encourages adoption of many of the Institute for Healthcare Improvement (IHI), the Agency for Healthcare Research & Quality (AHRQ), and The Joint Commission recommendations. In the past year we have implemented the following patient-centered care components: Rapid Response Team, Multi-disciplinary Rounding in the ICU, change of shift bedside report, updated our policy on Disruptive Physicians, Medication Reconciliation across the continuum, multi-disciplinary team meetings with nursing homes & long term care facilities to aid in the transition following the hospitalization, Patient Advocacy meetings when patient complaints are received, the IHI bundles for ventilators, central lines and urinary catheters, and an Open Visitation hospital policy. We feel that by implementing these components we have taken a comprehensive approach to improving the safety and quality of our care. Specifically by including the patient and family in the bedside report and in the multi-disciplinary team meetings we are ensuring that the patient is knowledgeable about their Plan of Care and goals for the day and are able to assist us in catching any errors that may occur. In this way we are addressing many of the concerns that are outlined in the report.

2A: What is the short-term improvement plan (next 12 months)?

In 2011 we will continue to participate in the Hospital Quality Reporting Initiative following the core measures from the Centers for Medicare and Medicaid for Pneumonia, Chest Pain, CHF and the Surgical Care Improvement project. We will begin participation with the National Database of Nursing Quality Indicators (NDNQI) along with continuing to implement patient-centered care components. We continue to follow the CDC's recommendations and the Association for Infection Prevention guidelines for our Infection Control program. We are currently working on a standardized Deep Vein Thrombosis (DVT) protocol for our post-op patients.

2B: How will the organization measure success?

We will monitor our HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey scores for opportunities for improvement. We will continue to have ongoing monitoring of quality indicators for our patient care departments. We will monitor our Hospital Compare reports and our NDNQI results for opportunities for improvement. We have a comprehensive Infection Surveillance program hospital-wide. We will continue to monitor our post-op patients for any complications.

3A: What is the long-term improvement plan (next 2-4 years)?

As we continue to work toward Planetree designation status as a best practice in improving the safety and quality of the care we provide, we will have monthly Planetree Steering Committee meetings. We are working towards Chest Pain Center Accreditation. We will have monthly Chest Pain Accreditation meetings.

3B: How will the organization measure success?

We will complete an organizational assessment of our progress towards Planetree designation in March of 2011. We will continue to have ongoing monitoring of quality indicators for our patient care departments. Hospital Compare, Infection Surveillance reports, Sentinel Event reports, and HCAHPS and NDNQI scores will be monitored for opportunities for improvement.

4: Please give a statement of commitment:

At Carson Valley Medical Center, our mission is to promote the health of our community by providing exceptional, compassionate care accessible to all. Our vision is to be recognized as the healthcare provider of choice, providing exceptional care by exceptional people. By working towards Planetree designation, implementing patient-centered care components, and working towards Chest Pain Center Accreditation, we are demonstrating our commitment to providing safe, high quality care to all patients.

I would also like to suggest that the State of Nevada consider requiring the certification of “Certified Professional in Healthcare Quality” for all hospital quality departments in order to ensure consistent implementation of the best practices as it does currently for the Infection Preventionists.

Centennial Hills Hospital Medical Center

address:
6900 N Durango Dr
Las Vegas NV 89149

phone number:
702-835-9700

website:
www.centennialhillshospital.com

accreditation:
The Joint Commission

average annual bed count:
171

date of last inspection:
December 30, 2009

categories of services provided:

medical | surgical | obstetrical | acute, non-critical access

services provided:

- anesthesia
- emergency department (dedicated)
- emergency services
- ICU – medical/surgical
- laboratory – clinical
- neonatal nursery
- obstetric service
- occupational therapy service
- operating rooms
- orthopedic surgery
- outpatient services
- pharmacy
- post-operative recovery rooms
- psychiatric services – emergency
- radiology services – diagnostic
- respiratory care services
- rehab – inpatient (CARF acc)
- speech pathology services
- surgical services – inpatient
- surgical services – outpatient

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Centennial Hills Hospital Medical Center, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	4 total inspections	
deficiency	**frequency**	**regulation**
assessment of patient	1	NAC 449.3624
nursing services	2	NAC 449.361
total deficiencies for this facility	**3**	

how to read this table:

This table shows the number of complaints received against Centennial Hills Hospital Medical Center, including state or federal regulation status and whether they were substantiated. The 1 other complaint was referred to another agency.

COMPLAINTS (January 1, 2009 – December 31, 2009)	8 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	4	3	1
federal	0	0	0
total complaints for this facility	**4**	**3**	**1**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Centennial Hills Hospital Medical Center, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	5 substantiated allegations	
allegation category	**sub-description**	**frequency**
quality of care/treatment	facility staffing	1
quality of care/treatment	resident left soiled for extended periods	1
resident/patient/client abuse	sexual	1
resident/patient/client assessment		1
resident/patient/client rights		1
total substantiated allegations for this facility		**5**

how to read this table:

This table shows the number of HACs that occurred at Centennial Hills Hospital Medical Center, including a title and frequency for each condition as well as its CMS condition number.

HOSPITAL-ACQUIRED CONDITIONS (January 1, 2009 – December 31, 2009)	15 total HACs	
condition	**frequency**	**condition number**
foreign object retained after surgery	0	1
air embolism	0	2
blood incompatibility	0	3
stage III and IV pressure ulcers	1	4
falls and trauma	8	5
manifestations of poor glycemic control	0	6
catheter-associated urinary tract infection	0	7
vascular catheter-associated infection	5	8
surgical site infection following coronary artery bypass graft – mediastinitis	0	9A
surgical site infection following bariatric surgery	0	9B
surgical site infection following orthopedic procedures	0	9C
deep vein thrombosis/pulmonary embolism	1	10
total conditions for this facility	**15**	

Centennial Hills Hospital Medical Center's Response to the 2009 Annual Hospitals Report

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

Based on the 2009 Nevada Hospital Report finding for hospitals and your organization, **identify priority areas** (i.e., healthcare acquired infections) for short-term and long-term improvement for your organization:

- Short Term Priorities:
  - Reduction in central line (CLABSI) and urinary tract infections (CAUTI)
  - Reduction in falls with serious injury
  - Reduction in hospital-acquired stage III & IV pressure ulcers
- Long Term Priorities:
  - Reduction in overall hospital-acquired infections (HAIs)
  - Reduction in overall hospital-acquired conditions (HACs)
  - Expansion of Deep Vein Thrombosis/Pulmonary Embolism (DVT/PE) protocols
  - Expansion of patient and community involvement in overall patient safety initiatives
  - Continued compliance with National Patient Safety Goals (NPSG)

2A: What is the short-term improvement plan (next 12 months)?

- Participate in the CUSP – BSI national initiative
- Establish protocols and practice to reduce overall use of urinary catheter device and early removal
- Implement all fall reduction strategies outlined by Institute for Healthcare Improvement and in Universal Health Services toolkit
- Implement best practices outlined in HealthInsight (Centers for Medicare and Medicaid 9th Scope of Work) initiative on pressure ulcers

2B: How will the organization measure success?

- Monitor and report all CLABSI to meet CDC benchmarks
- Improve Surgical Care Improvement Process (SCIP) measure compliance regarding urinary device removal
- Reduce falls with serious injury to under the national benchmark for acute care hospitals
- Reduce number of pressure ulcer incidents

3A: What is the long-term improvement plan (next 2-4 years)?

- Continue to identify compliance/opportunities to reduce HAIs and HACs
- Continue monitoring compliance of DVT/PE prophylactics (prevention) protocols
- Increase patient and community involvement in overall patient safety initiatives
- Continue complying with National Patient Safety Goals (NPSG)

3B: How will the organization measure success?

- Compare reduction of HAIs and HACs over previous years
- Compare reduction of DVTs/PEs over previous years
- Utilize social media tools to inform and engage community on patient safety
- Maintain accreditations and licenses

4: Please give a statement of commitment:

The Valley Health System, of which Centennial Hills Hospital Medical Center is a part, is committed to providing safe, effective health care for all patients through a mix of hardwired processes, ongoing patient, staff and physician education and improved technology.

ContinueCARE Hospital of Carson Tahoe

address:
775 Fleischmann Wy
Carson City NV 89703

phone number:
775-885-4140

website:
www.carsontahoe.com/main.asp?pid=49

accreditation:
The Joint Commission
(under Carson Tahoe Regional Medical Center)

bed count:
29

date of last inspection:
March 20, 2009

categories of services provided:

medical

services provided:

- dietetic service
- long term care (swing-beds)
- occupational therapy service
- physical therapy services
- psychiatric – geriatric
- radiology services – diagnostic
- respiratory care services
- renal dialysis (acute inpatient)
- speech pathology services

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at ContinueCARE Hospital of Carson Tahoe, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	1 total inspection	
deficiency	**frequency**	**regulation**
total deficiencies for this facility	**0**	

how to read this table:

This table shows the number of complaints received against ContinueCARE Hospital of Carson Tahoe, including state or federal regulation status and whether they were substantiated.

COMPLAINTS (January 1, 2009 – December 31, 2009)	1 total complaint		
complaint	**substantiated**	**unsubstantiated**	**other**
state	0	1	0
federal	0	0	0
total complaints for this facility	**0**	**1**	**0**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against ContinueCARE Hospital of Carson Tahoe, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	0 substantiated allegations	
allegation category	**sub-description**	**frequency**
total substantiated allegations for this facility		**0**

ContinueCARE Hospital of Carson Tahoe's Response to the 2009 Annual Hospitals Report

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

Based on the 2009 Nevada Hospital Report finding for hospitals and your organization, identify priority areas (i.e., healthcare acquired infections) for short-term and long-term improvement for your organization: Priorities are patient care. Reduced medication errors, reduced falls, and reduced nosocomial infections.

2A: What is the short-term improvement plan (next 12 months)?

We have implemented Interdisciplinary Team Meetings weekly. The members that attend these meetings weekly are nursing, respiratory therapy, pharmacy, dietary, social services, rehabilitation and wound care. This meeting is chaired by a physician. All patients are discussed with a priority of patient safety and progress with treatment goals.

2B: How will the organization measure success?

Track and trend incident reports, medication errors, patients in restraints, patient falls, satisfaction surveys, physician feedback and patient outcomes. Environment of Care rounds are done weekly to ensure patient safety.

3A: What is the long-term improvement plan (next 2-4 years)?

We have a new management company, and they are very helpful with resources, and we are purchasing capital and implementing quality plans we believe will help us achieve our goal of becoming the best Long Term Acute Care Hospital in Nevada. We plan to upgrade our Telemetry System, purchase Hi-Lo beds, a Vocera communication system will provide for better communication among care-givers.

3B: How will the organization measure success?

Facility has established benchmarks for each department. Facility is flexible and will add and subtract benchmarks as data dictates and goals are achieved. Facility staff through the monthly quality meetings, Medical Executive meetings and Governing Board meetings will address and implement steps to ensure patient safety.

4: Please give a statement of commitment:

We believe patients come first. We will lead with quality as indicated by physician-driven interdisciplinary team meetings. We will communicate as caregivers to facilitate compassionate patient care.

Desert Canyon Rehabilitation Hospital

address:
9175 W Oquendo Rd
Las Vegas NV 89148

phone number:
702-212-6589

website:
www.dcrh.net

certification:
CMS certified

bed count:
50

date of last inspection:
July 14, 2009

categories of services provided:

medical

services provided:

- blood bank
- dental service
- dietetic service
- laboratory – clinical
- occupational therapy service
- organ bank
- pharmacy
- physical therapy services
- radiology services – diagnostic
- respiratory care services
- rehab – inpatient (non-CARF)
- rehab – outpatient
- social services
- speech pathology services

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Desert Canyon Rehabilitation Hospital, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	2 total inspections	
deficiency	**frequency**	**regulation**
total deficiencies for this facility	**0**	

how to read this table:

This table shows the number of complaints received against Desert Canyon Rehabilitation Hospital, including state or federal regulation status and whether they were substantiated.

COMPLAINTS (January 1, 2009 – December 31, 2009)	2 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	1	1	0
federal	0	0	0
total complaints for this facility	**1**	**1**	**0**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Desert Canyon Rehabilitation Hospital, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	1 substantiated allegation	
allegation category	**sub-description**	**frequency**
quality of care/treatment	resident safety	1
total substantiated allegations for this facility		**1**

Desert Canyon Rehabilitation Hospital's Response to the 2009 Annual Hospitals Report

In response to the following questions, Desert Canyon Rehabilitation Hospital recognizes the importance of providing safe quality healthcare in a culture that promotes accountability and transparency and will use the following as an opportunity to reinforce our existing internal processes based upon nationally recognized guidelines as referenced below.

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

Reduce the use of physical restraints

2A: What is the short-term improvement plan (next 12 months)?

The hospital uses physical restraints as defined by The Joint Commission standards only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others. The hospital will implement the following plan to reduce the use of physical restraints:

- Interdisciplinary team to implement and update safety measures in the patient's individualized Plan of Care.
- Hourly rounding to address the patient's needs prior to request.
- Engage the Case Managers and Interdisciplinary staff during Team Conference to discuss less restrictive alternative methods, the patient's progress and discharge plan.

2B: How will the organization measure success?

Review of restraint medical records based on The Joint Commission standards and the Centers for Medicare and Medicaid Services guidelines. Monitor and report the restraint rate to the Safety Committee monthly, based on established benchmarks and previous data. Governing Body to make recommendations if trends are identified or the restraint rate exceeds the previous month.

3A: What is the long-term improvement plan (next 2-4 years)?

Significant reduction in the use of physical restraints based on hospital policy and procedure. Trial orders for restraints will not be accepted according to The Joint Commission standards.

3B: How will the organization measure success?

Medical record review for restraint reduction based on comparison of previous data analysis.

4: Please give a statement of commitment:

HealthSouth Rehabilitation Hospital of Las Vegas is committed to improving quality and patient safety based on nationally recognized guidelines and standards. The use of physical restraints will gradually decrease with the goal being a significant reduction.

Desert Springs Hospital Medical Center

address:
2075 E Flamingo Rd
Las Vegas NV 89119

phone number:
702-369-7610

website:
www.desertspringshospital.com

accreditation:
The Joint Commission

bed count:
286

date of last inspection:
December 15, 2009

categories of services provided:


medical


surgical


acute, non-critical access

services provided:

- anesthesia
- cardiac catheterization laboratory
- cardiac – thoracic surgery
- CT scanner
- dietetic service
- emergency department (dedicated)
- emergency services
- ICU – cardiac (non-surgical)
- ICU – medical/surgical
- ICU – medical
- laboratory – anatomical
- laboratory – clinical
- magnetic resonance imaging
- neurosurgical services
- nuclear medicine services
- occupational therapy service
- operating rooms
- opthalmic surgery
- orthopedic surgery
- outpatient services
- pharmacy
- physical therapy services
- post-operative recovery rooms
- psychiatric services – emergency
- radiology services – diagnostic
- radiology services – therapeutic
- respiratory care services
- renal dialysis (acute inpatient)
- social services
- speech pathology services
- surgical services – inpatient
- surgical services – outpatient
- urgent care center services

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Desert Springs Hospital Medical Center, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	8 total inspections	
deficiency	**frequency**	**regulation**
admission of patients	1	NAC 449.329
assessment of patient	3	NAC 449.3624
construction standards	1	NAC 449.3154
dietary services	1	NAC 449.338
discharge planning	4	NAC 449.332
housekeeping services	1	NAC 449.322
infections and communicable diseases	1	NAC 449.325
medical records	1	NAC 449.379
medical staff	1	NAC 449.358
nursing service	3	NAC 449.361
personnel policies	2	NAC 449.363
protection of patients	1	NAC 449.3628
total deficiencies for this facility	**20**	

how to read this table:

This table shows the number of complaints received against Desert Springs Hospital Medical Center, including state or federal regulation status and whether they were substantiated. Of the 4 other complaints, 1 is under investigation and 3 were referred to another agency.

COMPLAINTS (January 1, 2009 – December 31, 2009)	25 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	9	12	4
federal	0	0	0
total complaints for this facility	**9**	**12**	**4**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Desert Springs Hospital Medical Center, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	12 substantiated allegations	
allegation category	**sub-description**	**frequency**
admission, transfer and discharge rights		2
physician services	other	1
quality of care/treatment		1
quality of care/treatment	other	2
quality of care/treatment	responsible party not notified of resident's change in condition	1
resident/patient/client assessment		1
resident/patient/client neglect	assess/monitor	1
resident/patient/client rights	failed to acquire informed consent	2
state licensure	lack of protective supervision	1
total substantiated allegations for this facility		**12**

how to read this table:

This table shows the number of HACs that occurred at Desert Springs Hospital Medical Center, including a title and frequency for each condition as well as its CMS condition number.

HOSPITAL-ACQUIRED CONDITIONS (January 1, 2009 – December 31, 2009)	21 total HACs	
condition	**frequency**	**condition number**
foreign object retained after surgery	0	1
air embolism	0	2
blood incompatibility	0	3
stage III and IV pressure ulcers	2	4
falls and trauma	4	5
manifestations of poor glycemic control	0	6
catheter-associated urinary tract infection	1	7
vascular catheter-associated infection	12	8
surgical site infection following coronary artery bypass graft – mediastinitis	0	9A
surgical site infection following bariatric surgery	0	9B
surgical site infection following orthopedic procedures	0	9C
deep vein thrombosis/pulmonary embolism	2	10
total conditions for this facility	**21**	

Desert Springs Hospital Medical Center's Response to the 2009 Annual Hospitals Report

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

Based on the 2009 Nevada Hospital Report finding for hospitals and your organization, **identify priority areas** (i.e., healthcare acquired infections) for short-term and long-term improvement for your organization:

- Short Term Priorities:
  - Reduction in central line (CLABSI) and urinary tract infections (CAUTI)
  - Reduction in falls with serious injury
  - Reduction in hospital-acquired stage III & IV pressure ulcers
- Long Term Priorities:
  - Reduction in overall hospital-acquired infections (HAIs)
  - Reduction in overall hospital-acquired conditions (HACs)
  - Expansion of Deep Vein Thrombosis/Pulmonary Embolism (DVT/PE) protocols
  - Expansion of patient and community involvement in overall patient safety initiatives
  - Continued compliance with National Patient Safety Goals (NPSG)

2A: What is the short-term improvement plan (next 12 months)?

- Participate in the CUSP – BSI national initiative
- Establish protocols and practice to reduce overall use of urinary catheter device and early removal
- Implement all fall reduction strategies outlined by Institute for Healthcare Improvement and in Universal Health Services toolkit
- Implement best practices outlined in HealthInsight (Centers for Medicare and Medicaid 9th Scope of Work) initiative on pressure ulcers

2B: How will the organization measure success?

- Monitor and report all CLABSI to meet CDC benchmarks
- Improve Surgical Care Improvement Process (SCIP) measure compliance regarding urinary device removal
- Reduce falls with serious injury to under the national benchmark for acute care hospitals
- Reduce number of pressure ulcer incidents

3A: What is the long-term improvement plan (next 2-4 years)?

- Continue to identify compliance/opportunities to reduce HAIs and HACs
- Continue monitoring compliance of DVT/PE prophylactics (prevention) protocols
- Increase patient and community involvement in overall patient safety initiatives
- Continue complying with National Patient Safety Goals (NPSG)

3B: How will the organization measure success?

- Compare reduction of HAIs and HACs over previous years
- Compare reduction of DVTs/PEs over previous years
- Utilize social media tools to inform and engage community on patient safety
- Maintain accreditations and licenses

4: Please give a statement of commitment:

The Valley Health System, of which Desert Springs Hospital Medical Center is a part, is committed to providing safe, effective health care for all patients through a mix of hardwired processes, ongoing patient, staff and physician education and improved technology.

Desert View Regional Medical Center

address:
360 S Lola Ln
Pahrump NV 89048

phone number:
775-751-7500

website:
www.dvrmc.com

certification:
CMS certified

bed count:
24

date of last inspection:
June 4, 2009

categories of services provided:


medical


surgical

services provided:

- anesthesia
- blood bank
- CT scanner
- dietetic service
- emergency department (dedicated)
- emergency services
- laboratory – anatomical
- laboratory – clinical
- long term care (swing-beds)
- magnetic resonance imaging
- nuclear medicine services
- occupational therapy service
- operating rooms
- orthopedic surgery
- outpatient services
- pharmacy
- physical therapy services
- radiology services – diagnostic
- respiratory care services
- social services
- speech pathology services
- surgical services – inpatient
- surgical services – outpatient

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Desert View Regional Medical Center, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	2 total inspections	
deficiency	**frequency**	**regulation**
discharge planning	1	NAC 449.332
total deficiencies for this facility	**1**	

how to read this table:

This table shows the number of complaints received against Desert View Regional Medical Center, including state or federal regulation status and whether they were substantiated. No action was necessary for the 1 other complaint.

COMPLAINTS (January 1, 2009 – December 31, 2009)	4 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	1	2	1
federal	0	0	0
total complaints for this facility	**1**	**2**	**1**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Desert View Regional Medical Center, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	2 substantiated allegations	
allegation category	**sub-description**	**frequency**
admission, transfer and discharge rights		1
resident/patient/client assessment		1
total substantiated allegations for this facility		**2**

Desert View Regional Medical Center's Response to the 2009 Annual Hospitals Report

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

2A: What is the short-term improvement plan (next 12 months)?

Short-term goals are to implement the CMS ORYX Core measures as part of our overall commitment to improved quality care. These core measures will be adapted to this facility as a designated critical access hospital.

2B: How will the organization measure success?

We will measure the success of our program through concurrent chart audits, established APIC standards for determining infections, aggregate data compilations, and benchmarking with other hospitals that are comparable to our facility.

3A: What is the long-term improvement plan (next 2-4 years)?

As this facility brings on new services on board, we will be working to educate the staff and new members on Infection Control in the prevention of nosocomial infection spread. We will also develop policies and procedures to address safe patient care through use of established Infection Control Standards. We will also develop educational opportunities for our community in an effort to promote updating the general public on the prevention of spreading various diseases (i.e., H1N1 flu, TB, MMR, etc.). We will be collaborating with our local and state health representatives on prevention of community acquired infections.

3B: How will the organization measure success?

This will be measured by comparing the facility and community baseline statistics with the complied aggregate data at the end of 2009. This data will give us feedback on our success and identify areas for improvement.

4: Please give a statement of commitment:

Desert View Hospital is committed to caring for our community and as such is committed to providing safe, efficient and quality care within our capability. We are committed to utilizing staff, physician and patient feedback in the continued pursuit of providing excellence in patient care.

Desert Willow Treatment Center

address:
6171 W Charleston Blvd
Las Vegas NV 89146

phone number:
702-486-8900

website:
www.dcfs.state.nv.us/desertwillow.pdf

accreditation:
The Joint Commission

bed count:
58

date of last inspection:
August 24, 2009

categories of services provided:

psychiatric

services provided:

- alcohol and/or drug services
- psychiatric services – emergency
- psychiatric – child/adolescent
- psychiatric – inpatient

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Desert Willow Treatment Center, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	3 total inspections	
deficiency	**frequency**	**regulation**
nursing service	2	NAC 449.361
pharmaceutical services	1	NAC 449.340
physical restraint use	6	NAC 449.3628
protection of patient	4	NAC 449.3628
psychiatric services	2	NAC 449.394
quality improvement	1	NAC 449.3152
rights of patient	2	NAC 449.3626
total deficiencies for this facility	**18**	

how to read this table:

This table shows the number of complaints received against Desert Willow Treatment Center, including state or federal regulation status and whether they were substantiated.

COMPLAINTS (January 1, 2009 – December 31, 2009)	3 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	3	0	0
federal	0	0	0
total complaints for this facility	**3**	**0**	**0**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Desert Willow Treatment Center, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	5 substantiated allegations	
allegation category	**sub-description**	**frequency**
injury of unknown origin		1
quality of care/treatment	resident safety	1
resident/patient/client abuse	physical	1
resident/patient/client rights		1
restraints/seclusion – general		1
total substantiated allegations for this facility		**5**

Dini-Townsend Hospital
at Northern Nevada Adult Mental Health Services

address:
480 Galletti Wy
Sparks NV 89431

phone number:
775-688-2001

website:
mhds.nv.gov/index.php?option=com_content&task=view&id=23&Itemid=53

accreditation:
The Joint Commission

bed count:
70

date of last inspection:
December 16, 2009

categories of services provided:

psychiatric

services provided:

- dietetic service
- laboratory – clinical
- pharmacy
- psychiatric services – emergency
- psychiatric – inpatient
- psychiatric – outpatient
- social services

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Dini-Townsend Hospital at Northern Nevada Adult Mental Health Services, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	1 total inspection	
deficiency	**frequency**	**regulation**
personnel policies	1	NAC 449.363
total deficiencies for this facility	**1**	

how to read this table:

This table shows the number of complaints received against Dini-Townsend Hospital at Northern Nevada Adult Mental Health Services, including state or federal regulation status and whether they were substantiated.

COMPLAINTS (January 1, 2009 – December 31, 2009)	0 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	0	0	0
federal	0	0	0
total complaints for this facility	**0**	**0**	**0**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Dini-Townsend Hospital at Northern Nevada Adult Mental Health Services, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	0 substantiated allegations	
allegation category	**sub-description**	**frequency**
total substantiated allegations for this facility		**0**

Dini-Townsend Hospital at Northern Nevada Adult Mental Health Services' Response to the 2009 Annual Hospitals Report

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

Priority areas of focus for the short term are treatment planning, documentation and communication; for the long term, they are continuity of care and family involvement in planning.

2A: What is the short-term improvement plan (next 12 months)?

Our entire agency, including Dini-Townsend Hospital, has launched a Program Improvement Team (PIT), which will function over the next year to complete a process begun in the previous two years to improve both the quality and the frequency of completion of **treatment plans** that meet Joint Commission standards. We have made great progress as evidenced by our random audits. We will continue to add more elements to improve the quality and monitor to increase frequency and timeliness of completion. Ongoing training will support the continual upgrades in expectation and monthly random audits will measure our success.

Overall **documentation** in both inpatient and outpatient programs is another short term focus. The same PIT is training and auditing the quality of progress notes and whether or not they specifically address goals and interventions identified in the treatment plan.

The last short term focus is **communication**. We have developed an alert system for use by Dini-Townsend nurses to alert outpatient clinicians when a client has been hospitalized. We hope this will improve our continuity of care and speed up the process of joint discharge planning. We are currently auditing to be sure the nurses are actually using the new system and find that they are doing so.

2B: How will the organization measure success?

<no specific response>

3A: What is the long-term improvement plan (next 2-4 years)?

Improvements in the continuity of care both internally among our inpatient and outpatient programs and with the community of providers who also serve our consumers is a long term goal. This is important due to the complex problems routinely suffered by our consumers, including chronic health problems, substance abuse problems, poverty and lack of support systems. The specific improvements and the measures of success will be developed in our ongoing "Change Agent" group of staff from across the agency who are also inviting in representatives of partner agencies in the community.

Related to the continuity of care goal is our goal to increase family involvement in the care and discharge planning of our consumers. Although many do not have support systems, we are not maximizing the beneficial effect of having those who are involved in relationships with our consumers in their care. This information, perspective and source of support are invaluable in helping to stabilize consumers in the community. Our "Change Agent" group will also be addressing strategies to accomplish this goal as well as measure its success.

3B: How will the organization measure success?

<no specific response>

4: Please give a statement of commitment:

<no specific response>

Grover C Dils Medical Center

address:
700 N Spring St
Caliente NV 89008

phone number:
775-726-3171

website:
www.dilsmedicalcenter.org

certification:
CMS certified

bed count:
20

date of last inspection:
November 16, 2009

categories of services provided:


medical


acute, non-critical access

services provided:

- blood bank
- CT scanner
- emergency department (dedicated)
- laboratory – clinical
- long term care (swing-beds)
- outpatient services
- pediatric services
- radiology services – diagnostic
- social services

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Grover C Dils Medical Center, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	1 total inspection	
deficiency	**frequency**	**regulation**
direct services	1	485.635(b)(2)
direct services	1	485.635(b)(3)
nursing services	2	485.635(d)(4)
patient care policies	2	485.635(a)(3)(iv)
patient care policies	2	485.635(a)(3)(vi)
patient care policies	2	485.635(a)(3)(vii)
records systems	1	485.638(a)(4)(ii)
total deficiencies for this facility	**11**	

how to read this table:

This table shows the number of complaints received against Grover C Dils Medical Center, including state or federal regulation status and whether they were substantiated.

COMPLAINTS (January 1, 2009 – December 31, 2009)	0 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	0	0	0
federal	0	0	0
total complaints for this facility	**0**	**0**	**0**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Grover C Dils Medical Center, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	0 substantiated allegations	
allegation category	**sub-description**	**frequency**
total substantiated allegations for this facility		**0**

how to read this table:

This table shows the number of HACs that occurred at Grover C Dils Medical Center, including a title and frequency for each condition as well as its CMS condition number.

HOSPITAL-ACQUIRED CONDITIONS (January 1, 2009 – December 31, 2009)	0 total HACs	
condition	**frequency**	**condition number**
foreign object retained after surgery	0	1
air embolism	0	2
blood incompatibility	0	3
stage III and IV pressure ulcers	0	4
falls and trauma	0	5
manifestations of poor glycemic control	0	6
catheter-associated urinary tract infection	0	7
vascular catheter-associated infection	0	8
surgical site infection following coronary artery bypass graft – mediastinitis	0	9A
surgical site infection following bariatric surgery	0	9B
surgical site infection following orthopedic procedures	0	9C
deep vein thrombosis/pulmonary embolism	0	10
total conditions for this facility	**0**	

Grover C Dils Medical Center's Response to the 2009 Annual Hospitals Report

GCD
GROVER C. DILS MEDICAL CENTER
Bringing Quality Healthcare To The High Desert

2/9/2011

To whom may concern,

I am writing in response to the information request for the annual hospital report. Grover C. Dils Medical Center has made a few changes that need to be reflected in the next report. These changes are as follow:

- Grover C. Dils Medical Center is now a Critical Access Hospital (CAH).
- MRI services are no longer offered on site.
- The ambulance service is county-owned and not hospital-owned.

Along with these changes, I would like to issue a statement of our commitment to quality care and transparency. We recognize the importance of providing safe, quality healthcare in a culture that promotes accountability and transparency and will use the following as an opportunity to reinforce our existing internal processes based upon nationally recognized guidelines as referenced below. We are currently rated as a 5-star facility by Medicare and we plan to maintain this highest rating. The following is an explanation of our facility short-term and long-term plans for improvement.

Short-Term Improvement Plan

- Maintain and Improve our Infection Control Monitoring Program, according to standards of the CDC and APIC.
- Reporting and Monitoring CMS quality indicators for improved patient/resident care.
- Improve specific standards identified through LiCON Risk Management Assessment Practices and the Quality Assurance Committee audits. This is a process that is utilized throughout most Rural Hospitals.

These goals will be measured in out monthly Quality Assurance Committee Meeting as we benchmark against our own performance as well as other Nevada rural facilities. Each specific issue will be discussed, corrected and monitored for continued compliance.

Long-Term Improvement Plan

- By actively participating in the annual survey process, we will assure continued compliance to state and federal regulations.
- As a facility, we plan to expand care services in the laboratory and radiology fields to offer better diagnostic capabilities for our providers.
- We plan to upgrade technology in the laboratory and radiology departments as well as adopt a comprehensive electronic health record.
- Educational opportunities will be offered to our employees in the areas of patient care and safety, infection control, risk management, etc..

The success of these goals will be measured as new services, technology and training is realized. Monthly Quality Assurance Committee Meetings are held to assess the specific improvements and areas of need.

I feel that our facility Mission Statement serves as a clear direction and focus that we strive for here at Grover C. Dils Medical Center. Our mission is “To provide the highest quality healthcare in a compassionate, efficient, and cost-effective atmosphere that supports the dignity and well-being of those residing in our rural communities.”

Thank you for allowing me the opportunity to outline some of our goals and reiterate our commitment to providing quality patient/resident care.

Harmon Medical and Rehabilitation Hospital

address:
2170 E Harmon Ave
Las Vegas NV 89119

phone number:
702-794-0100

website:
www.fundltc.com/healthcare%20facility%20locator/facility_list.aspx?state=nv

certification:
CMS certified

bed count:
116

date of last inspection:
December 2, 2009

categories of services provided:

medical

services provided:

- dietetic service
- laboratory – clinical
- occupational therapy service
- pharmacy
- physical therapy services
- radiology services – diagnostic
- respiratory care services
- renal dialysis (acute inpatient)
- social services
- speech pathology services

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Harmon Medical and Rehabilitation Hospital, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	10 total inspections	
deficiency	**frequency**	**regulation**
administration of medication	1	NAC 449.344
appropriate care of patient	1	NAC 449.3622
assessment of patient	2	NAC 449.3624
discharge planning	1	NAC 449.332
housekeeping services	3	NAC 449.322
infections and communicable diseases	1	NAC 449.325
nursing service	2	NAC 449.361
patient rights	1	482.13
patient rights: restraint or seclusion	4	482.13(e)(4)(i)
patient rights: restraint or seclusion	3	482.13(f)
protection of patients	1	NAC 449.3628
rehabilitative services	1	NAC 449.346
use of restraint or seclusion	3	482.13(e)
total deficiencies for this facility	**24**	

how to read this table:

This table shows the number of complaints received against Harmon Medical and Rehabilitation Hospital, including state or federal regulation status and whether they were substantiated. Of the 4 other complaints, no action was necessary for 3, and 1 is under administrative/off-site investigation.

COMPLAINTS (January 1, 2009 – December 31, 2009)	37 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	17	16	4
federal	0	0	0
total complaints for this facility	**17**	**16**	**4**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Harmon Medical and Rehabilitation Hospital, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	22 substantiated allegations	
allegation category	**sub-description**	**frequency**
admission, transfer and discharge rights		1
infection control		1
physical environment	facility not clean	2
physical environment	other	1
physical environment	safe environment not provided	1
quality of care/treatment		2
quality of care/treatment	client service not performed per plan of correction and physician	1
quality of care/treatment	no pressure sore precautions taken by facility	1
quality of care/treatment	resident medications not given according to physician's instructions	1
quality of care/treatment	resident not groomed adequately	1
quality of care/treatment	resident safety	1
quality of care/treatment	resident safety/falls	1
rehabilitation services		1
resident/patient/client assessment		1
resident/patient/client neglect	assess/monitor	1
resident/patient/client neglect	medications	2
resident/patient/client neglect	pressure sores	1
resident/patient/client rights	resident's privacy not protected	1
state licensure	lack of protective supervision	1
total substantiated allegations for this facility		**22**

Harmon Medical and Rehabilitation Hospital's Response to the 2009 Annual Hospitals Report

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

Harmon Medical and Rehabilitation Hospital (HMRH) prides itself on our hospital-wide **Performance Improvement (PI) Program** based on survey findings, and self evaluation. In 2010, activities included a long-term **Infection Control** Quality Assurance Performance Improvement (QAPI) study as well as short term projects focused on **Housekeeping Practices**, and **In-House Acquired Wounds**. In 2011, we will continue our hospital-wide PI Program with projects focusing on **Wound Care Processes**, **Housekeeping Practices** and **Restrained Patient Protocols**. Long-term we will continue our work on the **Infection Control** QAPI and add Medication Administration and **Customer Service** as new multi-year studies.

2A: What is the short-term improvement plan (next 12 months)?

While there are short term goals and projects, our PI program strives for long-term effects. In 2010, activities addressed all areas outlined in previous survey findings and self evaluations. In 2011, HMRH will focus on maintaining successes and continued intervention in areas below benchmark. **Infection Rates** and **Housekeeping Services** received focused review, revision and education of processes. Similar activities for all areas identified on the PI Project Plan were implemented. Additionally, in 2011, we are pleased to be converting to an electronic health record system which we are confident will bring upon multiple benefits across the facility.

2B: How will the organization measure success?

To measure our success rate, HMRH follows all PI activities in a monthly meeting which reports up to the Executive Committee and Governing Body for direction. Audits are performed to track key indicators and action plans are established for indicators falling below benchmark.

3A: What is the long-term improvement plan (next 2-4 years)?

For the long-term, the PI program continues to track and trend any areas requiring intervention. Once benchmark is achieved and maintained for 3 months, it is followed in an Operations committee to ensure no slippage. The HMRH long term goals include reduced complaints and increased overall positive outcomes. To that extent, the PI program was redesigned in 2010 to address indicators hospital-wide, as well as implementation of no fewer than two long-term QAPI studies annually. In 2010, HMRH saw studies commence **for Case Management and Infection Control**, and 2011 will see the addition of QAPI studies based on **Medication Administration** and **Customer Service**.

3B: How will the organization measure success?

As with our short term goals, progress and success for our long term goals are trended and tracked via auditing and intervention as necessary. All key indicators, long-term or short, are continuously followed in the PI and Operations Committees with escalation to the Executive Committee or Governing Body for direction as required.

4: Please give a statement of commitment:

HMRH is committed to the following mission, vision and values for optimal outcomes: **Vision**: We work as an innovative healthcare team to provide positive health outcomes for our patients and a service-centered hospital experience for those entering our facility. **Mission**: We work together supporting our patients and their families with competent, professional and high quality care. We strive to provide the best care resulting in a safe and positive work environment for our employees, patients, families and medical providers. **Values**: These shall be our guiding principles and standards of behavior as we work together in providing quality clinical care and customer services. We value **quality patient care, empowerment, accountability, clear and consistent communication, professionalism and respect**.

HealthSouth Hospital at Tenaya

address:
2500 N Tenaya Wy
Las Vegas NV 89128

phone number:
702-562-2021

website:
www.healthsouthtenaya.com

accreditation:
The Joint Commission

bed count:
70

date of last inspection:
October 6, 2009

categories of services provided:

medical

services provided:

- dietetic service
- ICU – cardiac (non-surgical)
- laboratory – clinical
- occupational therapy service
- pharmacy
- physical therapy services
- psychiatric – inpatient
- radiology services – diagnostic
- respiratory care services
- rehab – inpatient (non-CARF)
- renal dialysis (acute inpatient)
- social services
- speech pathology services

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at HealthSouth Hospital at Tenaya, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	2 total inspections	
deficiency	**frequency**	**regulation**
appropriate care of patient	1	NAC 449.3622
medical records	1	NAC 449.379
medication orders	1	NAC 449.343
nursing services	2	NAC 449.361
personnel policies	1	NAC 449.363
physical restraint use	2	NAC 449.3628
quality of care/policies procedures	1	NAC 449.314
social services	2	NAC 449.352
total deficiencies for this facility	**11**	

how to read this table:

This table shows the number of complaints received against HealthSouth Hospital at Tenaya, including state or federal regulation status and whether they were substantiated.

COMPLAINTS (January 1, 2009 – December 31, 2009)	1 total complaint		
complaint	**substantiated**	**unsubstantiated**	**other**
state	0	1	0
federal	0	0	0
total complaints for this facility	**0**	**1**	**0**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against HealthSouth Hospital at Tenaya, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	0 substantiated allegations	
allegation category	**sub-description**	**frequency**
total substantiated allegations for this facility		**0**

HealthSouth Hospital at Tenaya's Response to the 2009 Annual Hospitals Report

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

In response to the following questions, we recognize the importance of providing safe, quality health care in a culture that promotes accountability and transparency and will use the following as an opportunity to reinforce our existing internal processes based upon nationally recognized guidelines as referenced below.

The identified priority area was breakdown in communication. This includes written or verbal communication involving all clinical caregivers, patients and their families. The Joint Commission cites ineffective communication as a major cause of sentinel events.

2A: What is the short-term improvement plan (next 12 months)?

- Tools used for written communication were revised and implemented (Joint Commission, n.d.).
- Implement Situation, Background, Assessment, and Recommendation (SBAR) hand off communication (Joint Commission, n.d.).
- Implement hourly rounding to improve patient communication with caregivers (Hardwiring Excellence, Quint Studer, 2010).
- Revise policies and educate staff on policy revisions.

2B: How will the organization measure success?

- Open and closed chart audits.
- Clinical outcomes for hospital-acquired conditions will be below benchmarks established by Acute Long Term Hospital Association (ALTHA).
- Patient Experience Audits by external auditing agency (Press Ganey).

3A: What is the long-term improvement plan (next 2-4 years)?

- Include patients in end of shift report.
- Implement Wellness Information Tools Home (patient education) handbooks.
- Revise nursing documentation tool to increase the time a caregiver spends at the patient's bedside.

3B: How will the organization measure success?

- Open and close chart reviews to measure performance with clinical indicators.
- Outcomes will be aggregated and benchmarked against other Long Term Acute Care (LTAC) hospitals. The hospital uses the Acute Long Term Hospital Association (ALTHA) benchmarks.

4: Please give a statement of commitment:

It is our commitment at HealthSouth Hospital at Tenaya to foster an environment that supports the identification, reporting, and response to potential and actual occurrences. Improving communication has a positive impact on patient care. Our ultimate goal is to achieve the highest standard of quality and services as part of the health care continuum.

HealthSouth Rehabilitation Hospital of Henderson

address:
10301 Jeffreys St
Henderson NV 89052

phone number:
702-939-9400

website:
www.hendersonrehabhospital.com

accreditation:
The Joint Commission

bed count:
70

date of last inspection:
August 5, 2009

categories of services provided:

medical

services provided:

- home health services
- occupational therapy service
- outpatient services
- pharmacy
- physical therapy services
- respiratory care services
- rehab – inpatient (non-CARF)
- rehab – outpatient

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at HealthSouth Rehabilitation Hospital of Henderson, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	2 total inspections	
deficiency	**frequency**	**regulation**
appropriate care of patient	1	NAC 449.3622
assessment of patient	1	NAC 449.3624
nursing service	3	NAC 449.361
nutritional status of patients	1	NAC 449.339
pharmaceutical services	1	NAC 449.340
total deficiencies for this facility	**7**	

how to read this table:

This table shows the number of complaints received against HealthSouth Rehabilitation Hospital of Henderson, including state or federal regulation status and whether they were substantiated. The 3 other complaints are under administrative/off-site investigation.

COMPLAINTS (January 1, 2009 – December 31, 2009)	5 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	2	0	3
federal	0	0	0
total complaints for this facility	**2**	**0**	**3**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against HealthSouth Rehabilitation Hospital of Henderson, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	3 substantiated allegations	
allegation category	**sub-description**	**frequency**
quality of care/treatment	resident medications not given according to physician's instructions	1
quality of care/treatment	resident medications improperly administered	1
resident/patient/client neglect	assess/monitor	1
total substantiated allegations for this facility		**3**

HealthSouth Rehabilitation Hospital of Henderson's Response to the 2009 Annual Hospitals Report

In response to the following questions, we recognize the importance of providing safe, quality health care in a culture that promotes accountability and transparency and will use the following as an opportunity to reinforce our existing internal processes based upon nationally recognized guidelines as referenced below.

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

- Assessment/ care of patients
- Hospital-acquired conditions

2A: What is the short-term improvement plan (next 12 months)?

Provide a safe environment for patients, employees, physicians, allied health professionals, contract staff, volunteers, students, and visitors by identifying risks in the delivery of services through:

- Providing re-education on the fall prevention program, based on fall data analysis and comparisons over previous years of reductions or improvements.
- Initiating new Performance Improvement team for medication management processes, according to TJC National Patient Safety Goals & Standards.
- Increasing staff awareness of hospital acquired conditions and reporting mechanisms, according to CDC and World Healthcare Organization (WHO) Guidelines.

2B: How will the organization measure success?

- Completion of clinical staff education based on current Nursing Practice Guidelines and performance indicators.
- Monitoring fall rates, based on fall data analysis and comparisons over previous years of reductions or improvements.

Findings are reported, actions recommended, and evaluation of effectiveness reported through various committees.

3A: What is the long-term improvement plan (next 2-4 years)?

- Goal is to identify and reduce the risks in the delivery of patient care services among our selected population relating to hospital-acquired conditions based on CDC, WHO, and TJC Standards/guidelines.

3B: How will the organization measure success?

- Targeted process audits and medical record review, based on comparisons over previous years of reductions or improvements.
- Education with coaching, based on comparisons over previous years of reductions or improvements.
- Monitoring of attendance records for training and competency, based on hospital policy.

4: Please give a statement of commitment:

HealthSouth of Henderson is 100% committed to deliver quality health and safe patient care to the community and population that we serve.

HealthSouth Rehabilitation Hospital of Las Vegas

address:
1250 S Valley View Blvd
Las Vegas NV 89102

phone number:
702-877-8898

website:
www.healthsouthlasvegas.com/

accreditation:
The Joint Commission

bed count:
79

date of last inspection:
September 15, 2009

categories of services provided:

medical

services provided:

- occupational therapy service
- pediatric services
- pharmacy
- physical therapy services
- radiology services – diagnostic
- social services

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at HealthSouth Rehabilitation Hospital of Las Vegas, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	1 total inspection	
deficiency	**frequency**	**regulation**
appropriate care of patient	1	NAC 449.3622
medical records	2	NAC 449.379
personnel policies	1	NAC 449.363
physical restraint use	3	NAC 449.3628
sanitary conditions and supplies for food	1	NAC 449.3395
social services	2	NAC 449.352
total deficiencies for this facility	**10**	

how to read this table:

This table shows the number of complaints received against HealthSouth Rehabilitation Hospital of Las Vegas, including state or federal regulation status and whether they were substantiated.

COMPLAINTS (January 1, 2009 – December 31, 2009)	1 total complaint		
complaint	**substantiated**	**unsubstantiated**	**other**
state	0	1	0
federal	0	0	0
total complaints for this facility	**0**	**1**	**0**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against HealthSouth Rehabilitation Hospital of Las Vegas, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	0 substantiated allegations	
allegation category	**sub-description**	**frequency**
total substantiated allegations for this facility		**0**

HealthSouth Rehabilitation Hospital of Las Vegas's Response to the 2009 Annual Hospitals Report

In response to the following questions, HealthSouth Rehabilitation Hospital of Las Vegas recognizes the importance of providing safe quality healthcare in a culture that promotes accountability and transparency and will use the following as an opportunity to reinforce our existing internal processes based upon nationally recognized guidelines as referenced below.

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

Reduce the use of physical restraints.

2A: What is the short-term improvement plan (next 12 months)?

The hospital uses physical restraints as defined by The Joint Commission standards only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others. The hospital will implement the following plan to reduce the use of physical restraints:

- Interdisciplinary team to implement and update safety measures in the patient's Individualized Plan of Care.
- Hourly rounding to address the patient's needs prior to request.
- Engage the Case Managers and Interdisciplinary staff during Team Conference to discuss less restrictive alternative methods, the patient's progress and discharge plan.

2B: How will the organization measure success?

Review of restraint medical records based on The Joint Commission standards and the Centers for Medicare and Medicaid Services guidelines. Monitor and report the restraint rate to the Safety Committee monthly, based on established benchmarks and previous data. Governing Body to make recommendations if trends are identified or the restraint rate exceeds the previous month.

3A: What is the long-term improvement plan (next 2-4 years)?

Significant reduction in the use of physical restraints based on hospital policy and procedure. Trial orders for restraints will not be accepted according to The Joint Commission standards.

3B: How will the organization measure success?

Medical record review for restraint reduction based on comparison of previous data analysis.

4: Please give a statement of commitment:

HealthSouth Rehabilitation Hospital of Las Vegas is committed to improving quality and patient safety based on nationally recognized guidelines and standards. The use of physical restraints will gradually decrease with the goal being a significant reduction.

Horizon Specialty Hospital – Las Vegas

address:
640 Desert Ln
Las Vegas NV 89106

phone number:
702-382-3155

website:
www.fundltc.com/healthcare%20facility%20locator/facility_list.aspx?state=nv

accreditation:
The Joint Commission

bed count:
199

date of last inspection:
November 14, 2009

categories of services provided:

medical

services provided:

- dietetic service
- ICU – cardiac (non-surgical)
- ICU – medical/surgical
- laboratory – clinical
- occupational therapy services
- pharmacy
- physical therapy services
- respiratory care services
- rehab – inpatient (CARF acc)
- social services
- speech pathology services

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Horizon Specialty Hospital – Las Vegas, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	1 total inspection	
deficiency	**frequency**	**regulation**
personnel policies	1	NAC 449.363
total deficiencies for this facility	**1**	

how to read this table:

This table shows the number of complaints received against Horizon Specialty Hospital – Las Vegas, including state or federal regulation status and whether they were substantiated.

COMPLAINTS (January 1, 2009 – December 31, 2009)	2 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	0	2	0
federal	0	0	0
total complaints for this facility	**0**	**2**	**0**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Horizon Specialty Hospital – Las Vegas, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	0 substantiated allegations	
allegation category	**sub-description**	**frequency**
total substantiated allegations for this facility		**0**

Humboldt General Hospital

address:
118 E Haskell St
Winnemucca NV 89445

phone number:
775-623-5222

website:
www.hghospital.ws

certification:
CMS certified

bed count:
52

date of last inspection:
November 12, 2008

categories of services provided:

medical surgical obstetrical

services provided:

- ambulance services (owned)
- anesthesia
- blood bank
- CT scanner
- dietetic service
- emergency department (dedicated)
- ICU – medical/surgical
- laboratory – clinical
- long term care (swing-beds)
- magnetic resonance imaging
- nuclear medicine services
- obstetric service
- operating rooms
- outpatient services
- pediatric services
- pharmacy
- physical therapy services
- post-operative recovery rooms
- psychiatric services – emergency
- radiology services – diagnostic
- respiratory care services
- rehab – inpatient (non-CARF)
- rehab – outpatient
- social services
- speech pathology services
- surgical services – inpatient
- surgical services – outpatient

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Humboldt General Hospital, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	0 total inspections	
deficiency	**frequency**	**regulation**
total deficiencies for this facility	**0**	

how to read this table:

This table shows the number of complaints received against Humboldt General Hospital, including state or federal regulation status and whether they were substantiated.

COMPLAINTS (January 1, 2009 – December 31, 2009)	0 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	0	0	0
federal	0	0	0
total complaints for this facility	**0**	**0**	**0**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Humboldt General Hospital, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	0 substantiated allegations	
allegation category	**sub-description**	**frequency**
total substantiated allegations for this facility		**0**

Humboldt General Hospital's Response to the 2009 Annual Hospitals Report

In response to the following questions, we recognize the importance of providing safe, quality health care in a culture that promotes accountability and transparency and will use the following as an opportunity to reinforce our existing internal processes based upon nationally recognized guidelines as referenced below.

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

- Overall, we are reviewing all of our processes to determine areas for improvement in order to ensure a consistent level of service delivery. We will utilize AHRQ, IHI, NDNQI, as resources for establishing guidelines for improvement.

2A: What is the short-term improvement plan (next 12 months)?

- Implement Quality Improvement Plan which sets the program for improvement and quality.

2B: How will the organization measure success?

- Organization will measure success by establishing target goals and organization's overall compliance with the target goals.

3A: What is the long-term improvement plan (next 2-4 years)?

- Obtain accreditation through either The Joint Commission or similar accrediting body.

3B: How will the organization measure success?

- Success will come with achieving accreditation.

4: Please give a statement of commitment:

- As an organization, Humboldt General Hospital is committed to providing the highest level of quality care and service to the population served. This is accomplished through review of processes and procedures to ensure that the delivery of care and service meets identified metrics/goals.

Incline Village Community Hospital

address:
880 Alder St
Incline Village NV 89451

phone number:
775-833-4100

website:
www.tfhd.com/inclinehospital.asp

accreditation:
AOA's Healthcare Facilities Accreditation Program

bed count:
4

date of last inspection:
November 2, 2009

categories of services provided:

medical

surgical

services provided:

- anesthesia
- blood bank
- CT scanner
- dietetic service
- emergency department (dedicated)
- emergency services
- home health services
- hospice
- laboratory – clinical
- occupational therapy services
- operating rooms
- orthopedic surgery
- outpatient services
- pediatric services
- physical therapy services
- post-operative recovery rooms
- radiology services – diagnostic
- social services
- surgical services – inpatient
- surgical services – outpatient

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Incline Village Community Hospital, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	2 total inspections	
deficiency	**frequency**	**regulation**
final observation	1	
sterile supplies and medical equipment	1	NAC 449.327
total deficiencies for this facility	**2**	

how to read this table:

This table shows the number of complaints received against Incline Village Community Hospital, including state or federal regulation status and whether they were substantiated.

COMPLAINTS (January 1, 2009 – December 31, 2009)	0 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	0	0	0
federal	0	0	0
total complaints for this facility	**0**	**0**	**0**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Incline Village Community Hospital, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	0 substantiated allegations	
allegation category	**sub-description**	**frequency**
total substantiated allegations for this facility		**0**

Incline Village Community Hospital's Response to the 2009 Annual Hospitals Report

Incline Village Community Hospital recognizes the importance of providing the highest level of safe, quality care for the patients and community we serve. Our organization has a systematic performance improvement framework to improve patient outcomes and reduce the risks associated with patient safety in a manner that embraces the mission of our organization; Devoted to Excellence, Your Health, Your Life, Our Passion. We promote a culture of safety and quality and utilize nationally recognized guidelines and accreditation criteria to support continuous performance improvement and patient safety to provide each patient safe, timely, effective, efficient, equitable and patient-centered care.

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

Based on the 2009 Nevada Hospital Report finding for hospitals and your organization, identify priority areas (i.e., healthcare acquired infections) for short-term and long-term improvement for your organization:

2A: What is the short-term improvement plan (next 12 months)?

1. Our organization's short-term improvement plan will follow the Health Care Facilities Accreditation Program Infection Control criteria which states, *The hospital provides a sanitary environment to avoid sources and transmission of infections and communicable diseases. There is an active program for the prevention, control and investigation of infections and communicable disease*. Our plan will be to ensure our steam autoclave is maintained per manufacturer's recommendation to provide a sanitary environment to avoid transmission of infections in the use of surgical equipment.

2. As recommended by the National Quality Forum for safe practice for surgical-site infection prevention, we will take action to prevent surgical-site infections.

2B: How will the organization measure success?

1. The Organization will measure its success for manufacturer's recommendation for maintaining the autoclave through quarterly monitoring of documentation in Sterilization log for cleaning of filter and initialing by staff. Results will be reported at the Hospital Wide Infection Control Committee meeting in 2011.

2. As recommended by the National Quality Forum to prevent surgical-site infections and Healthcare Facilities Accreditation Program we will measure success by:

   a. Monitor administration of prophylactic antibiotics within one hour of incision time of surgical procedure.

   b. Identify surgical site infections, investigate infection and calculate surgical site infections rates and report rates quarterly to Surgery Department Meeting and Infection Control Committee.

   c. IVCH has joined the Nevada State Infection Prevention Initiative. Their resources will be utilized to assess current program and identify improvement opportunities.

3A: What is the long-term improvement plan (next 2-4 years)?

1. The National Patient Safety Goals recommend improving the safe use of medications. We will prevent medication errors through the utilization of an automated medication dispensing system.

2. As recommended by the National Quality Forum for safe practice for surgical-site infection prevention, we will take action to prevent surgical-site infections.

3. As recommended by the National Quality Forum for safe practice we will measure our culture of safety, provide feedback to leadership and staff, and undertake interventions that will reduce patient safety risk.

3B: How will the organization measure success?

1. To prevent medication errors we will measure success by:

    a) Installation of an automated medication dispensing system that will help identify unknown medication errors that have occurred. Medication error rate will be reported quarterly to the Pharmacy and Therapeutics Committee. Process improvement activity will be implemented to improve medication reconciliation process.

2. As recommended by the National Quality Forum to prevent surgical-site infections and Healthcare Facilities Accreditation Program we will measure success by:

    a) Monitoring administration of prophylactic antibiotics within one hour of incision time of surgical procedure.

    b) Identifying surgical site infections, investigating infections, calculating surgical site infections rates, and reporting rates quarterly to Surgery Department Meeting and Infection Control Committee.

3. As recommended by the National Quality Forum to undertake interventions that will reduce patient safety risk we will measure success by:

    a) Conducting a safety survey using nationally recognized tool and portray the results of the culture survey in a report that is shared with leadership, staff, and the Medical Staff Quality Committee.

    b) Analyzing results and identify process improvements based on the survey results.

4: Please give a statement of commitment:

Incline Village Community Hospital is committed to providing the highest level of care possible for the community we serve and the patients that require our services. Through the integration of medical staff, nursing, allied health, administrative systems, with continuous performance improvement and patient safety, we will provide to each patient safe, timely, effective, efficient, equitable and patient-centered care.

Kindred Hospital – Las Vegas (Flamingo Campus)

address:
2250 E Flamingo Rd
Las Vegas NV 89119

phone number:
702-784-4300

website:
www.kindredhospitallvf.com

accreditation:
The Joint Commission
(under Kindred Hospital – Las Vegas (Sahara Campus))

bed count:
146

date of last inspection:
December 29, 2009

categories of services provided:

medical

services provided:

- dietetic service
- ICU – medical/surgical
- occupational therapy service
- pharmacy
- physical therapy services
- radiology services – diagnostic
- respiratory care services
- rehab – inpatient (non-CARF)
- rehab – outpatient
- renal dialysis (acute inpatient)
- social services
- speech pathology services

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Kindred Hospital – Las Vegas (Flamingo Campus), including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	2 total inspections	
deficiency	**frequency**	**regulation**
rights of patient	1	NAC 449.3626
total deficiencies for this facility	**1**	

how to read this table:

This table shows the number of complaints received against Kindred Hospital – Las Vegas (Flamingo Campus), including state or federal regulation status and whether they were substantiated. No action was necessary for the 1 other complaint.

COMPLAINTS (January 1, 2009 – December 31, 2009)	4 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	1	2	1
federal	0	0	0
total complaints for this facility	**1**	**2**	**1**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Kindred Hospital – Las Vegas (Flamingo Campus), including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	1 substantiated allegation	
allegation category	**sub-description**	**frequency**
resident/patient/client rights	other	1
total substantiated allegations for this facility		**1**

Kindred Hospital – Las Vegas (Flamingo Campus)'s Response to the 2009 Annual Hospitals Report

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

The priority focus as a result of the 2009 findings is to provide or assist patients in obtaining interpretation or translation services as necessary.

2A: What is the short-term improvement plan (next 12 months)?

Kindred Hospital Flamingo respects the patient's right to effective communication appropriate to the language of that patient. Nurses assess language barriers on all newly admitted patients. Translation services are provided for non-English speaking patients using Language Line Services. Language Line Services provided the hospital with poster boards, brochures and quick reference guides. These materials are made available to the clinical staff and the posters are in the clinical areas for patients and families to use. Staff is educated on the use of the Language Line Services materials.

2B: How will the organization measure success?

The Nurse Manager monitors admission documentation and takes corrective action (education or counseling) as needed to ensure ongoing assessments area completed. Complaints and grievances are also monitored by Administration.

3A: What is the long-term improvement plan (next 2-4 years)?

Kindred will continue to contract with Language Line Services and ensure the proper education and resources are made available to staff.

3B: How will the organization measure success?

Success will be recognized as Nurse Manager Audits continue to meet established goals and by the lack of complaints and grievances associated with language barriers.

4: Please give a statement of commitment:

The constant pursuit of excellence is our top priority.

Meeting and exceeding customer expectations is a philosophy that governs every aspect of our operations at Kindred. Our Strategic Quality Initiative is a long-range process that is customer-focused and the basis of our organizational performance improvement efforts. Our Strategic Quality Initiative is more than a plan for improvement; it is a way of thinking, an atmosphere that fosters the highest standards of care and service.

Kindred Hospital – Las Vegas (Sahara Campus)

address:
5110 W Sahara Ave
Las Vegas NV 89146

phone number:
702-871-1418

website:
www.kindredhospitallvs.com

accreditation:
The Joint Commission

bed count:
52

date of last inspection:
December 1, 2009

categories of services provided:

medical

services provided:

- dietetic service
- ICU – medical/surgical
- occupational therapy service
- pharmacy
- physical therapy services
- radiology services – diagnostic
- respiratory care services
- rehab – inpatient (non-CARF)
- rehab – outpatient
- renal dialysis (acute inpatient)
- social services
- speech pathology services

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Kindred Hospital – Las Vegas (Sahara Campus), including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	2 total inspections	
deficiency	**frequency**	**regulation**
appropriate care of patient	1	NAC 449.3622
assessment of patient	2	NAC 449.3624
discharge planning	1	NAC 449.332
housekeeping services	3	NAC 449.322
personnel policies	1	NAC 449.363
pharmaceutical services	1	NAC 449.340
physical restraint use	1	NAC 449.3628
sanitary conditions – supplies for food	3	NAC 449.3395
total deficiencies for this facility	**13**	

how to read this table:

This table shows the number of complaints received against Kindred Hospital – Las Vegas (Sahara Campus), including state or federal regulation status and whether they were substantiated.

COMPLAINTS (January 1, 2009 – December 31, 2009)	1 total complaint		
complaint	**substantiated**	**unsubstantiated**	**other**
state	0	1	0
federal	0	0	0
total complaints for this facility	**0**	**1**	**0**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Kindred Hospital – Las Vegas (Sahara Campus), including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	0 substantiated allegations	
allegation category	**sub-description**	**frequency**
total substantiated allegations for this facility		**0**

Kindred Hospital – Las Vegas at Desert Springs Hospital

address:
2075 E Flamingo Rd
Las Vegas NV 89119

phone number:
702-784-4300

website:
www.kindredhospitallvds.com

accreditation:
The Joint Commission
(under Kindred Hospital – Las Vegas (Sahara Campus))

bed count:
40

date of last inspection:
August 12, 2009

categories of services provided:

medical

services provided:

- occupational therapy service
- pharmacy
- physical therapy services
- radiology services – diagnostic
- respiratory care services
- rehab – inpatient (non-CARF)
- rehab – outpatient
- renal dialysis (acute inpatient)
- social services
- speech pathology services

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Kindred Hospital – Las Vegas at Desert Springs Hospital, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	2 total inspections	
deficiency	**frequency**	**regulation**
total deficiencies for this facility	**0**	

how to read this table:

This table shows the number of complaints received against Kindred Hospital – Las Vegas at Desert Springs Hospital, including state or federal regulation status and whether they were substantiated.

COMPLAINTS (January 1, 2009 – December 31, 2009)	1 total complaint		
complaint	**substantiated**	**unsubstantiated**	**other**
state	0	1	0
federal	0	0	0
total complaints for this facility	**0**	**1**	**0**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Kindred Hospital – Las Vegas at Desert Springs Hospital, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	0 substantiated allegations	
allegation category	**sub-description**	**frequency**
total substantiated allegations for this facility		**0**

Lake's Crossing Center

address:
500 Galletti Wy
Sparks NV 89431

phone number:
775-688-1900

website:
mhds.nv.gov/index.php?option=com_content&task=view&id=76&Itemid=50

certification:
not CMS certified

bed count:
56

date of last inspection:
June 9, 2008

categories of services provided:

psychiatric

services provided:

- dietetic service
- laboratory – clinical
- pharmacy
- psychiatric – forensic
- social services

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Lake's Crossing Center, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	0 total inspections	
deficiency	**frequency**	**regulation**
total deficiencies for this facility	**0**	

how to read this table:

This table shows the number of complaints received against Lake's Crossing Center, including state or federal regulation status and whether they were substantiated.

COMPLAINTS (January 1, 2009 – December 31, 2009)	0 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	0	0	0
federal	0	0	0
total complaints for this facility	**0**	**0**	**0**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Lake's Crossing Center, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	0 substantiated allegations	
allegation category	**sub-description**	**frequency**
total substantiated allegations for this facility		**0**

Lake's Crossing Center's Response to the 2009 Annual Hospitals Report

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

<no specific response>

2A: What is the short-term improvement plan (next 12 months)?

GOAL 1: Improve the accuracy of patient identification.

Performance improvement monitoring: We will investigate any medication errors for system identification problems and our target will be one or less a quarter.

GOAL 2: Improve the effectiveness of communications among caregivers.

All discharges will be reviewed by a supervisor to ensure that follow up caregivers are given all pertinent information. Strict departmental inter shift reporting will be completed to identify all potential safety concerns including PRN medication, potential for aggression, self harm seizure precautions and fall risks if any.

Performance improvement monitoring: Peer review, supervisor involvement and monitoring the electronic medical record. All falls will be investigated to reduce future risk factors; no more than one fall a quarter.

GOAL 3: Improve the safety of using medications.

Anytime a physician stops a medication secondary to an untoward reaction, a document will be sent to the pharmacy to prevent future orders for that medication. Pharmacy and nursing leadership will meet monthly to identify safety issues, and report to the Patient Safety Committee.

Performance improvement monitoring: Medication errors to be tabulated and broken down for cause analysis. Supervisors will offer guidance in major medication reactions, e.g., NMS and signs of specific toxicity and how to communicate with physicians effectively. Nursing leadership will evaluate this communication with the Medical Director.

GOAL 4: Reduce the risk of healthcare associated infections.

All infections are monitored by the Infection Control Committee. Patterns of Nosocomal infections will be identified and remedied. Emphasis on MRSA treatment and prevention will be maintained.

Performance improvement monitoring: MRSA infections will be identified on admission, cultures performed and isolation and prevention methods used. No more than one Nosocomal MRSA infection a quarter.

GOAL 5: Accurately and completely reconcile medications across the continuum of care.

All admission medications will be written on the day of admission, reviewed by the medical doctor and reviewed by the pharmacy for accuracy, efficacy and safety.

Performance improvement monitoring: Monitoring of the nursing care plan, first dose of medication documentation, and ensuring treatment planning for pain and infections, no more than one exception per quarter.

GOAL 6: Reduce the risk of patient harm resulting from falls.

Identify on admission and throughout the stay any fall risk and monitor closely.

Performance improvement monitoring: All falls will be investigated to reduce future risk factors; no more than one fall a quarter. Monitor care planning through peer review; no more than one exception a quarter.

GOAL 7: Encourage patients' active involvement in their own care as a patient safety strategy.

All primary care nurses to meet weekly with their clients to incorporate self identified hazards during care.

Performance improvement monitoring: Peer review of nursing care documentation to identify training needs and building of a therapeutic relationship. No more than one exception a quarter.

GOAL 8: The organization identifies safety risk inherent in its patient population.

The organization is currently reviewing the restraint and seclusion process and documentation to ensure the least restrictive environment possible.

Performance improvement monitoring: Adaption of the draft policy and implementation by the next report.

2B: How will the organization measure success?

Performance improvement monitoring: We will investigate any medication errors for system identification problems and our target will be one or less a quarter.

All discharges will be reviewed by a supervisor to ensure that follow up caregivers are given all pertinent information. Strict departmental inter shift reporting will be completed to identify all potential safety concerns including PRN medication, potential for aggression, self harm seizure precautions, and fall risks if any.

Anytime a physician stops a medication secondary to an untoward reaction, a document will be sent to the pharmacy to prevent future orders for that medication. Pharmacy and nursing leadership will meet monthly to identify safety issues, and report to the Patient Safety Committee.

All infections are monitored by the Infection Control Committee. Patterns of nosocomal infections will be identified and remedied. Emphasis on MRSA treatment and prevention will be maintained.

Identify on admission and throughout the stay any fall risk and monitor closely.

All admission medications will be written on the day of admission, reviewed by the medical doctor and reviewed by the pharmacy for accuracy, efficacy and safety.

All primary care nurses to meet weekly with their clients to incorporate self identified hazards during care.

The organization is currently reviewing the restraint and seclusion process and documentation to ensure the least restrictive environment possible. The facility is in the process of instituting regular analysis of data to establish trends and appropriate interventions to reduce seclusion and restraint events.

3A: What is the long-term improvement plan (next 2-4 years)?

GOAL 1. Reduce the hours of restraint and seclusion.

Measure the hours reported to the division and document the percent per client hours.

GOAL 2. Establish an agency department, independent of the nursing department for Quality Assurance Monitoring and leadership.

MHDS will budget and staff this department.

GOAL 3. Increase professionalism of line Staff.

Written staff development plan will be included in the Human Resource section of the agency policy manual.

GOAL 4. Increase clinical interactions that extend beyond restoration of competency and focus on the enhancement of client functioning in environments encountered after discharge.

Increase clinical interventions by professional staff as measured by the electronic medical record.

3B: How will the organization measure success?

Measure the seclusion and restraint hours reported to the division and document percentage of reduction in these hours per total client hours.

MHDS will budget and staff a Quality Assurance Department when funding becomes available.

A written staff Development Plan is to be included in the Human Resource section of the agency policy manual.

The agency will seek to increase clinical interventions by professional staff as measured by the electronic medical record.

4: Please give a statement of commitment:

The forensic services' mission is to provide a superior level of care in a maximum security psychiatric setting. The facility will provide the courts and the community high quality forensic treatment and evaluation of the mentally ill offender. In providing these services the agency will strive to perform care at a consistent level of excellence in a challenging environment.

Mesa View Regional Hospital

address:
1299 Bertha Howe Ave
Mesquite NV 89027

phone number:
702-346-8040

website:
www.mesaviewhospital.com

accreditation:
The Joint Commission

bed count:
25

date of last inspection:
March 12, 2009

categories of services provided:

medical surgical obstetrical

services provided:

- anesthesia
- audiology
- chiropractic service
- CT scanner
- dental service
- dietetic service
- emergency department (dedicated)
- emergency services
- hospice
- ICU – medical/surgical
- laboratory – clinical
- long term care (swing-beds)
- magnetic resonance imaging
- nuclear medicine services
- obstetric service
- occupational therapy service
- operating rooms
- opthalmic surgery
- orthopedic surgery
- outpatient services
- pediatric services
- pharmacy
- physical therapy services
- post-operative recovery rooms
- radiology services – diagnostic
- reconstructive services
- respiratory care services
- speech pathology services
- surgical services – inpatient
- surgical services – outpatient

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Mesa View Regional Hospital, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	1 total inspection	
deficiency	**frequency**	**regulation**
total deficiencies for this facility	**0**	

how to read this table:

This table shows the number of complaints received against Mesa View Regional Hospital, including state or federal regulation status and whether they were substantiated.

COMPLAINTS (January 1, 2009 – December 31, 2009)	0 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	0	0	0
federal	0	0	0
total complaints for this facility	**0**	**0**	**0**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Mesa View Regional Hospital, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	0 substantiated allegations	
allegation category	**sub-description**	**frequency**
total substantiated allegations for this facility		**0**

Montevista Hospital

address:
5900 W Rochelle Ave
Las Vegas NV 89103

phone number:
702-364-1111

website:
www.psysolutions.com/facilities/montevista/

accreditation:
The Joint Commission

bed count:
80

date of last inspection:
August 19, 2009

categories of services provided:

psychiatric

services provided:

- alcohol and/or drug services
- anesthesia
- CT scanner
- dental service
- dietetic service
- laboratory – clinical
- magnetic resonance imaging
- outpatient services
- pharmacy
- psychiatric services – emergency
- psychiatric – child/adolescent
- psychiatric – geriatric
- psychiatric – inpatient
- psychiatric – outpatient
- radiology services – diagnostic
- social services

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Montevista Hospital, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	3 total inspections	
deficiency	**frequency**	**regulation**
total deficiencies for this facility	**0**	

how to read this table:

This table shows the number of complaints received against Montevista Hospital, including state or federal regulation status and whether they were substantiated.

COMPLAINTS (January 1, 2009 – December 31, 2009)	4 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	0	4	0
federal	0	0	0
total complaints for this facility	**0**	**4**	**0**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Montevista Hospital, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	0 substantiated allegations	
allegation category	**sub-description**	**frequency**
total substantiated allegations for this facility		**0**

Montevista Hospital's Response to the 2009 Annual Hospitals Report

Montevista Hospital has developed and implemented a well-defined, organized risk management program designed to ensure safety and enhance the quality of patient care. In our response, Montevista Hospital recognizes the importance of providing safe, quality health care in a culture which promotes accountability and transparency while utilizing this opportunity to reinforce existing internal processes based upon nationally recognized guidelines.

Our Performance Improvement Plan focuses on the important functions and processes of the organization to improve the quality of patient care, patient safety, patient outcomes, and enhances the value of our services along with improving our operational efficiency.

The results of the 2009 report show three (3) inspections with no deficiencies and four complaints that were unsubstantiated. With our focus on quality care, patient outcomes, and patient safety, we will continue to identify areas for improvement, gather data, implement corrective action plans where necessary and monitor compliance. This information is then presented at Patient Safety Committee, Infection Control Committee, and Environment of Care Committee, as well as our monthly Quality Council Committee, the Medical Executive Committee, and the Governing Board.

Montevista Hospital is committed to maintaining the achievements of our performance improvement activities and will continue to improve these processes and maintain compliance with ethical and regulatory standards.

Mount Grant General Hospital

address:
200 S A St
Hawthorne NV 89415

phone number:
775-945-2461

website:
www.mtgrantgenhospital.org

certification:
CMS certified

bed count:
35

date of last inspection:
May 12, 2009

categories of services provided:

medical

surgical

services provided:

- ambulance services (owned)
- anesthesia
- audiology
- CT scanner
- emergency department (dedicated)
- laboratory – clinical
- long term care (swing-beds)
- magnetic resonance imaging
- operating rooms
- opthalmic surgery
- outpatient services
- pharmacy
- physical therapy services
- radiology services – diagnostic
- respiratory care services
- surgical services – outpatient

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Mount Grant General Hospital, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	5 total inspections	
deficiency	**frequency**	**regulation**
dietary services	1	NAC 449.338
nursing services	1	485.635(d)
nursing services	1	485.635(d)(3)
nursing services	1	485.635(d)(4)
patient care policies	1	485.635(a)(3)(iv)
patient care policies	2	485.635(a)(3)(vii)
patient care policies	3	485.635(a)(4)
provision of services	1	485.635
records systems	1	485.638(a)(4)(i)
records systems	1	485.638(a)(4)(ii)
total deficiencies for this facility	**13**	

how to read this table:

This table shows the number of complaints received against Mount Grant General Hospital, including state or federal regulation status and whether they were substantiated. The 1 other complaint was referred to another agency.

COMPLAINTS (January 1, 2009 – December 31, 2009)	1 total complaint		
complaint	**substantiated**	**unsubstantiated**	**other**
state	0	0	1
federal	0	0	0
total complaints for this facility	**0**	**0**	**1**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Mount Grant General Hospital, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	0 substantiated allegations	
allegation category	**sub-description**	**frequency**
total substantiated allegations for this facility		**0**

MountainView Hospital

address:
3100 N Tenaya Wy
Las Vegas NV 89128

phone number:
702-255-5000

website:
www.mountainview-hospital.com

accreditation:
The Joint Commission

bed count:
235

date of last inspection:
November 6, 2009

categories of services provided:

medical | surgical | obstetrical | acute, non-critical access

services provided:

- anesthesia
- blood bank
- cardiac catheterization laboratory
- cardiac – thoracic surgery
- chemotherapy service
- CT scanner
- dietetic service
- emergency department (dedicated)
- emergency services
- ICU – cardiac (non-surgical)
- ICU – medical/surgical
- ICU – neonatal
- ICU – pediatric
- ICU – surgical
- laboratory – anatomical
- laboratory – clinical
- magnetic resonance imaging
- neonatal nursery
- nuclear medicine services
- obstetric service
- occupational therapy service
- operating rooms
- orthopedic surgery
- outpatient services
- pediatric services
- pharmacy
- physical therapy services
- post-operative recovery rooms
- radiology services – diagnostic
- radiology services – therapeutic
- respiratory care services
- rehab – outpatient
- renal dialysis (acute inpatient)
- social services
- speech pathology services
- surgical services – inpatient
- surgical services – outpatient

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at MountainView Hospital, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	7 total inspections	
deficiency	**frequency**	**regulation**
appropriate care of patient	1	NAC 449.3622
assessment of patient	1	NAC 449.3624
discharge planning	2	NAC 449.332
governing body	1	NAC 449.313
nursing service	1	NAC 449.361
quality improvement	1	NAC 449.3152
quality of care	1	NAC 449.314
total deficiencies for this facility	**8**	

how to read this table:

This table shows the number of complaints received against MountainView Hospital, including state or federal regulation status and whether they were substantiated. The 2 other complaints were referred to another agency.

COMPLAINTS (January 1, 2009 – December 31, 2009)	16 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	2	12	2
federal	0	0	0
total complaints for this facility	**2**	**12**	**2**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against MountainView Hospital, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	5 substantiated allegations	
allegation category	**sub-description**	**frequency**
physician services	other	1
quality of care/treatment	care/services not received per physician's order	1
quality of care/treatment	physician not notified of resident change in condition	1
resident/patient/client assessment		1
resident/patient/client rights	resident's privacy not protected	1
total substantiated allegations for this facility		**5**

how to read this table:

This table shows the number of HACs that occurred at MountainView Hospital, including a title and frequency for each condition as well as its CMS condition number.

HOSPITAL-ACQUIRED CONDITIONS (January 1, 2009 – December 31, 2009)	41 total HACs	
condition	**frequency**	**condition number**
foreign object retained after surgery	0	1
air embolism	0	2
blood incompatibility	0	3
stage III and IV pressure ulcers	4	4
falls and trauma	7	5
manifestations of poor glycemic control	3	6
catheter-associated urinary tract infection	1	7
vascular catheter-associated infection	24	8
surgical site infection following coronary artery bypass graft – mediastinitis	1	9A
surgical site infection following bariatric surgery	0	9B
surgical site infection following orthopedic procedures	0	9C
deep vein thrombosis/pulmonary embolism	1	10
total conditions for this facility	**41**	

MountainView Hospital's Response to the 2009 Annual Hospitals Report

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

Top three priorities consist of eliminating healthcare-associated infections (HAI), reducing hospital-acquired conditions (HAC) and implementing an electronic health record.

2A: What is the short-term improvement plan (next 12 months)?

MountainView Hospital has launched an internal initiative called The Aim for Zero Campaign. This campaign utilizes specific evidence-based strategies to eliminate HAIs. The campaign focuses on central line-associated blood stream infections. It expands on the insertion bundle that Dr. Peter Pronovost developed in the Keystone Project and adds a second unique bundle focusing on maintenance of central lines.

MountainView is also one of a select group of hospitals participating in a "REDUCE MRSA" trial or Randomized Evaluation of Decolonization vs. Universal Clearance to Eliminate Methicillin Resistant *Staphylococcus Aureus*. This leading research was developed in partnership with the CDC, AHRQ and Harvard.

2B: How will the organization measure success?

HAI, HAC, Sentinel Events and HCAHPS data will all indicate if improvement is achieved.

3A: What is the long-term improvement plan (next 2-4 years)?

By 2015, MountainView Hospital will implement a fully integrated Electronic Health Record (EHR). An EHR is a secure, real-time, point-of-care, patient-centric information resource for clinicians. The EHR aids clinicians' decision-making by providing access to patient health record information where and when they need it and by incorporating evidence-based decision support. The EHR automates and streamlines the clinician's workflow, closing loops in communication and response that result in delays or gaps in care. The EHR also supports the collection of data for uses other than direct clinical care, such as billing, quality management, outcomes reporting, resource planning, and public health disease surveillance and reporting (HIMSS Electronic Health Record Definitional Model Version 1.1). It is our belief that the EHR will be one of the most fundamental support systems for optimizing the safety, quality, effectiveness and efficiency of healthcare that we provide in our facility.

3B: How will the organization measure success?

By accomplishing Stages I, II and III of Meaningful Use set by the HITECH Act.

4: Please give a statement of commitment:

Our initiatives harmonize with the best practice recommendations set forth by the NQF's Safe Practices and The Joint Commission's standards. We collaborate with local and national patient safety organizations, including NHA Patient Safety Committee; the Southern Nevada Health District; HealthInsight; the Institute for Safe Medication Practices; the Institute for Healthcare Improvement; the Leapfrog Group; and the National Patient Safety Foundation, all in an effort to ensure a safe environment and experience for our patients, staff and physicians.

North Vista Hospital

address:
1409 E Lake Mead Blvd
N Las Vegas NV 89030

phone number:
702-649-7711

website:
www.northvistahospital.com

accreditation:
The Joint Commission,
Det Norske Veritas

bed count:
178

date of last inspection:
November 18, 2009

categories of services provided:

medical | surgical | obstetrical | psychiatric | acute, non-critical access

services provided:

- anesthesia
- blood bank
- cardiac catheterization laboratory
- CT scanner
- dietetic service
- emergency department (dedicated)
- emergency services
- ICU – medical/surgical
- laboratory – clinical
- magnetic resonance imaging
- nuclear medicine services
- occupational therapy services
- operating rooms
- opthalmic services
- orthopedic surgery
- outpatient services
- pharmacy
- physical therapy services
- post-operative recovery rooms
- psychiatric – geriatric
- radiology services – diagnostic
- respiratory care services
- renal dialysis (acute inpatient)
- social services
- speech pathology services
- surgical services – inpatient
- surgical services – outpatient

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at North Vista Hospital, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	12 total inspections	
deficiency	**frequency**	**regulation**
adequate respiratory care staffing	1	482.57(a)(2)
administration of drugs	1	482.23(c)
appropriate care of patient	2	NAC 449.3622
assessment of patients	1	NAC 449.3624
blood gases/lab test requirements	1	482.57(b)(2)
construction standards	2	NAC 449.3154
discharge planning	1	NAC 449.332
housekeeping services	1	NAC 449.322
infection control officer responsibilities	1	482.42(a)(1)
infections and communicable diseases	1	NAC 449.325
life safety code standard	38	NFPA 101
nursing services	1	482.23
nursing services	1	NAC 449.361
physical environment	1	NAC 449.316
potentially infectious blood/blood products	1	482.27(b)
protection of patients	1	NAC 449.3628
RN supervision of nursing care	2	482.23(b)(3)
unusable drugs not used	1	482.25(b)(3)
total deficiencies for this facility	**58**	

how to read this table:

This table shows the number of complaints received against North Vista Hospital, including state or federal regulation status and whether they were substantiated. Of the 6 other complaints, 5 were referred, and 1 is under administrative/off-site investigation.

COMPLAINTS (January 1, 2009 – December 31, 2009)	18 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	6	5	6
federal	1	0	0
total complaints for this facility	**7**	**5**	**6**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against North Vista Hospital, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	11 substantiated allegations	
allegation category	**sub-description**	**frequency**
admission, transfer and discharge rights		1
physical environment	facility not clean	2
quality of care/treatment	inappropriate feeding assistance for weight loss resident	1
quality of care/treatment	other	2
quality of care/treatment	resident medications improperly administered	1
quality of care/treatment	resident not assessed after change in condition timely	1
resident/patient/client assessment		2
resident/patient/client neglect	injury of unknown origin	1
total substantiated allegations for this facility		**11**

how to read this table:

This table shows the number of HACs that occurred at North Vista Hospital, including a title and frequency for each condition as well as its CMS condition number.

HOSPITAL-ACQUIRED CONDITIONS (January 1, 2009 – December 31, 2009)	10 total HACs	
condition	**frequency**	**condition number**
foreign object retained after surgery	0	1
air embolism	0	2
blood incompatibility	0	3
stage III and IV pressure ulcers	2	4
falls and trauma	3	5
manifestations of poor glycemic control	1	6
catheter-associated urinary tract infection	0	7
vascular catheter-associated infection	3	8
surgical site infection following coronary artery bypass graft – mediastinitis	0	9A
surgical site infection following bariatric surgery	0	9B
surgical site infection following orthopedic procedures	0	9C
deep vein thrombosis/pulmonary embolism	1	10
total conditions for this facility	**10**	

North Vista Hospital's Response to the 2009 Annual Hospitals Report

At North Vista Hospital, we believe in constantly improving both the quality of care we provide and the service we offer. One of the ways we do that is by measuring ourselves, so we can find out how we're doing compared to other, similar institutions. In addition, we are advocates and participate in initiatives to improve the quality and safety of patient care, in collaboration with leading quality organizations such as the Institute for Healthcare Improvement (IHI), the Agency for Healthcare Research and Quality (AHRQ), and National Quality Forum (NQF).

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

As part of its commitment to operational excellence, North Vista Hospital participates in an innovative quality improvement program that uses comparative data to detect inefficiencies, prioritize opportunities, and set improvement goals. This quality improvement program is called the Hospital Medical Management and Quality Program (HMMQP), which standardizes data-driven performance management procedures across the organization. Today, the HMMQP is the program that North Vista Hospital relies upon to leverage best practices and refine processes in its quest to continually improve the overall clinical operations of our hospital and the quality and safety of care we provide. The program provides us with a resource to identify top priorities for improvement through risk-adjusted outcome measures.

In line with the HMMQP infrastructure, North Vista Hospital's priorities include:

- Detecting operational inefficiencies that can lead to better patient outcomes
- Prioritizing process improvements based upon risk-adjusted outcome measures
- Setting clinical operational improvement goals to achieve best practices in patient care outcomes.

2A: What is the short-term improvement plan (next 12 months)?

Over the next 12 month's North Vista Hospital will expand its information systems, as part of the hospital parent company's continued efforts to deliver high quality patient care. This information technology expansion includes physician documentation as well as computerized provider order entry (CPOE), with completion expected by 2011. While most U.S. hospitals still rely on handwritten physician instructions for their patients' care, CPOE will enable the physicians at North Vista Hospital to enter patient orders electronically. With orders for nursing, pharmacy, laboratory and radiology departments submitted electronically and updated in a single, secure electronic health record, the system's various care teams will be able to improve information-sharing and access the latest patient information when and where it is needed. Additionally, computerized provider order entry technology is designed to help reduce the possibility of medication errors due to adverse drug interactions. North Vista Hospital is proud to be the first in Southern Nevada to implement this cutting edge patient safety technology.

2B: How will the organization measure success?

As part of the measurement process, we are commitment to “transparency,” which includes reviewing the most current internal quality data available. While the hospital’s HMMQP is an internal tool used to drive quality improvements, North Vista Hospital is sharing its results with the public via its Quality Dashboard on the hospital’s Internet site. The Quality Dashboard shows how North Vista Hospital is doing at providing the right care, at the right time, to the patients we serve. Information about care outcomes, certain types of infections, and how patients view their experiences at North Vista Hospital is included on the Quality Dashboard. Much of this information is being posted in advance of, or prior to, State and Federal releases of the information. The hospital compares itself to national benchmarks and strives for Top 10% achievement in many indicators, and thus, uses these benchmarks to measure our success.

3A: What is the long-term improvement plan (next 2-4 years)?

North Vista Hospital’s long-term improvement plans include accreditations for centers of excellence and hospital-specific service lines. In addition, as part of the hospital’s accreditation program through DNV Healthcare, Inc. the hospital plans to integrate its quality management compliance program through an additional certification program known as ISO9001 (International Standards Organization).

3B: How will the organization measure success?

North Vista Hospital will measure success by achieving ISO 9001 certification and will monitor compliance and success through a fully developed internal auditing program.

4: Please give a statement of commitment:

North Vista Hospital is committed to "Quality" in patient care, which means something very specific: it refers to clinical outcomes. North Vista Hospital will continue to make improvements in procedures and processes so we can always be as safe as possible.

Northeastern Nevada Regional Hospital

address:
2001 Errecart Blvd
Elko NV 89801

phone number:
775-738-5151

website:
www.nnrhospital.com

accreditation:
The Joint Commission

bed count:
75

date of last inspection:
October 5, 2009

categories of services provided:

medical | surgical | obstetrical | acute, non-critical access

services provided:

- anesthesia
- blood bank
- cardiac catheterization laboratory
- chemotherapy service
- CT scanner
- dietetic service
- emergency department (dedicated)
- emergency services
- ICU – medical/surgical
- laboratory – clinical
- magnetic resonance imaging
- nuclear medicine services
- obstetric service
- occupational therapy services
- operating rooms
- opthalmic surgery
- orthopedic surgery
- outpatient services
- pediatric services
- pharmacy
- physical therapy services
- post-operative recovery rooms
- radiology services – diagnostic
- radiology services – therapeutic
- respiratory care services
- renal dialysis (acute inpatient)
- social services
- speech pathology
- surgical services – inpatient
- surgical services – outpatient

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Northeastern Nevada Regional Hospital, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	3 total inspections	
deficiency	**frequency**	**regulation**
physical environment	1	NAC 449.316
sterile supplies and medical equipment	1	NAC 449.327
total deficiencies for this facility	**2**	

how to read this table:

This table shows the number of complaints received against Northeastern Nevada Regional Hospital, including state or federal regulation status and whether they were substantiated. The 1 other complaint was referred to another agency.

COMPLAINTS (January 1, 2009 – December 31, 2009)	5 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	2	2	1
federal	0	0	0
total complaints for this facility	**2**	**2**	**1**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Northeastern Nevada Regional Hospital, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	2 substantiated allegations	
allegation category	**sub-description**	**frequency**
physical environment	equipment not maintained	1
physical environment	safe environment not provided	1
total substantiated allegations for this facility		**2**

how to read this table:

This table shows the number of HACs that occurred at Northeastern Nevada Regional Hospital, including a title and frequency for each condition as well as its CMS condition number.

HOSPITAL-ACQUIRED CONDITIONS (January 1, 2009 – December 31, 2009)	7 total HACs	
condition	**frequency**	**condition number**
foreign object retained after surgery	1	1
air embolism	0	2
blood incompatibility	0	3
stage III and IV pressure ulcers	0	4
falls and trauma	4	5
manifestations of poor glycemic control	0	6
catheter-associated urinary tract infection	2	7
vascular catheter-associated infection	0	8
surgical site infection following coronary artery bypass graft – mediastinitis	0	9A
surgical site infection following bariatric surgery	0	9B
surgical site infection following orthopedic procedures	0	9C
deep vein thrombosis/pulmonary embolism	0	10
total conditions for this facility	**7**	

Northeastern Nevada Regional Hospital's Response to the 2009 Annual Hospitals Report

Short Term Priorities include, but are not limited to: Hospital Wide Environment of Care Safety, patient falls, adherence to the universal protocols for surgical and invasive procedures, and infection prevention and control.

Long Term Priorities include: continued monitoring of systemic processes that involve high risk, high volume, and problem prone areas that relate to or help meet NNRH's goals and objectives: reduce costs, improve quality, safety, and service and risk reduction.

Short Term and Long Term Improvement Plans – NNRH will continue to focus on meeting the intent of the National Patient Safety Goals, Core Measures, federal and state guidelines/standards, The Joint Commission Standards, and any other reports or measures that impact quality patient care by recognizing that performance improvement is paramount to quality patient care and patient safety. These plans and subsequent data collection and analyses are presented to physicians, staff and governing board members at scheduled meetings. The performance improvement process is an organized, structured process that selectively identifies improvement projects related to key functions and may employ interdepartmental project teams to achieve improvements. NNRH utilizes the Plan-Do-Check-Act strategy or model to systematically and continuously measure and improve performance.

Measurement of Success - The program activities shall include measures related to each function. Data is obtained through performance improvement project follow-up studies, practice reviews, and departmental reviews, both concurrent and retrospective. A benchmark, cap or target is selected or developed for each measure. The benchmarks are set by the Quality Council, Medical Executive Committee, hospital leadership, or are researched through literature. Benchmarks are the predetermined levels or points at which intensive evaluation of measures are indicated. The following information systems and standardized reporting systems are utilized to support Performance Improvement and Monitoring Activities: Health Information Systems, Performance Improvement Reports, Patient Satisfaction Reports, Customer Complaint Reports, Occurrence Reporting, Physician Satisfaction Surveys, Employee Satisfaction Surveys, National Patient Safety Goals, The Joint Commission Standards, federal/state standards, and Core Measures Data.

Commitment Statement - NNRH is fully committed to the belief that improving patient safety is the most important challenge that we face in the healthcare industry and in our hospital. The hospital has approved and utilizes a Safety Plan and its purpose is to develop mechanisms to integrate and coordinate the activities of all of our healthcare staff so that patient safety is the foremost concern at every stage of every process that we conduct. Patient safety is the number one priority in the design of new processes, in the evaluation of existing processes and in the re-design of existing processes. The hospital-wide goal is to be proactive in preventing errors and complications. To accomplish this goal, we are committed to comparing ourselves to national databases using the latest evidence-based guidelines, searching for "best practices," studying designs of systems, and always searching for methods of strengthening our existing system designs by adding risk reduction strategies. Senior leaders regularly evaluate the culture of safety and quality using valid and reliable tools and prioritize and implement changes based on such evaluations. All individuals who work in the hospital are able to participate in safety and quality initiatives, either on an individual basis or a team approach. Staff, including the medical staff, are encouraged to discuss any areas of concern that impact patient safety and quality. Relevant literature concerning patient and staff safety is distributed throughout the hospital in the form of flyers, posters, newsletters and through staff meetings. Patients and their family members are encouraged to speak with the hospital staff concerning any safety/quality issues.

Northern Nevada Medical Center

address:
2375 E Prater Wy
Sparks NV 89434

phone number:
755-356-4001

website:
www.northernnvmed.com

accreditation:
The Joint Commission

bed count:
100

date of last inspection:
October 13, 2009

categories of services provided:

medical | surgical | psychiatric | acute, non-critical access

services provided:

- alcohol and/or drug services
- anesthesia
- audiology
- cardiac catheterization laboratory
- CT scanner
- dietetic service
- emergency department (dedicated)
- emergency services
- gerontological specialty services
- ICU –medical/surgical
- ICU –surgical
- laboratory – clinical
- magnetic resonance imaging
- neurosurgical services
- nuclear medicine services
- occupational therapy services
- operating rooms
- orthopedic surgery
- outpatient services
- pharmacy
- physical therapy services
- post-operative recovery rooms
- psychiatric services – emergency
- psychiatric – geriatric
- psychiatric – inpatient
- psychiatric – outpatient
- radiology services – diagnostic
- radiology services – therapeutic
- reconstructive services
- respiratory care services
- rehab – inpatient (non-CARF)
- rehab – outpatient
- renal dialysis (acute inpatient)
- social services
- speech pathology services
- surgical services – inpatient
- surgical services – outpatient

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Northern Nevada Medical Center, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	6 total inspections	
deficiency	**frequency**	**regulation**
on call physicians	1	489.20(r)(2) & 489.24(j)(1-2)
physical restraint use	1	NAC 449.3628
quality of care/policies procedures	1	NAC 449.314
rights of patient	1	NAC 449.3626
total deficiencies for this facility	**4**	

how to read this table:

This table shows the number of complaints received against Northern Nevada Medical Center, including state or federal regulation status and whether they were substantiated. The 1 other complaint is under administrative/off-site investigation.

COMPLAINTS (January 1, 2009 – December 31, 2009)	8 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	2	4	1
federal	1	0	0
total complaints for this facility	**3**	**4**	**1**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Northern Nevada Medical Center, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	3 substantiated allegations	
allegation category	**sub-description**	**frequency**
EMTALA (patient dumping)	physician on-call list	1
resident/patient/client assessment		1
restraints/seclusion – general		1
total substantiated allegations for this facility		**3**

how to read this table:

This table shows the number of HACs that occurred at Northern Nevada Medical Center, including a title and frequency for each condition as well as its CMS condition number.

HOSPITAL-ACQUIRED CONDITIONS (January 1, 2009 – December 31, 2009)	10 total HACs	
condition	**frequency**	**condition number**
foreign object retained after surgery	0	1
air embolism	0	2
blood incompatibility	0	3
stage III and IV pressure ulcers	0	4
falls and trauma	3	5
manifestations of poor glycemic control	2	6
catheter-associated urinary tract infection	0	7
vascular catheter-associated infection	3	8
surgical site infection following coronary artery bypass graft – mediastinitis	0	9A
surgical site infection following bariatric surgery	0	9B
surgical site infection following orthopedic procedures	1	9C
deep vein thrombosis/pulmonary embolism	1	10
total conditions for this facility	**10**	

Northern Nevada Medical Center's Response to the 2009 Annual Hospitals Report

Northern Nevada MEDICAL CENTER

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

- Short Term Priorities:
  - Reduction in overall falls
  - Reduction in central line-associated blood steam infections (CLABSI) and catheter-associated urinary tract infections (CAUTI)
- Long Term Priorities:
  - Expansion of patient and community education in overall patient safety initiatives
  - Reduction in overall hospital-acquired infections (HAIs)
  - Reduction in overall hospital-acquired conditions (HACs)
  - Continued compliance with National Patient Safety Goals (NPSG)

2A: What is the short-term improvement plan (next 12 months)?

- Monitor implemented fall reduction strategies outlined by Institute for Healthcare Improvement and in Universal Health Services toolkit
- Participate in the CDC and State of Nevada Comprehensive Unit-Based Safety Program (CUSP), which is designed to reduce CLABSIs
- Monitor protocols and practice to reduce overall use of urinary catheter devices and ensure their early removal

2B: How will the organization measure success?

- Benchmark facility performance and compare to hospitals across the nation, as well as for improvement over prior years
- Monitor facility outcomes and report all CLABSI in order to meet CDC benchmarks
- Monitor Surgical Care Improvement Process (SCIP) and measure compliance regarding urinary device removal

3A: What is the long-term improvement plan (next 2-4 years)?

- Monitor facility compliance and implement policy and process in order to reduce HAIs and HACs
- Increase patient and community education in overall patient safety initiatives
- Continued compliance with National Patient Safety Goals (NPSG)

3B: How will the organization measure success?

- Benchmark facility performance compared to hospitals across the nation, as well as for improvement over prior years
- Maintain required accreditations and licenses, as well as pursue additional certifications and center of excellence accreditations to further demonstrate our focus on the highest quality of care standards

4: Please give a statement of commitment:

Northern Nevada Medical Center is committed to providing safe, quality, personalized healthcare.

NNMC is fully accredited by The Joint Commission and voluntarily participates in numerous programs to foster and continually measure process improvement. NNMC is proud of its low incidence of HAIs and HACs, and we attribute our success to the various programs we participate in including:

- CDC and State of Nevada CUSP Program
- Pursuing Chest Pain Center certification by the Society of Chest Pain Centers
- Pursuing accreditation as a Stroke Center by The Joint Commission
- Catch a Falling Star fall prevention program
- Caring Moments in Nursing program
- American Heart Association's Get with the Guidelines program

Nye Regional Medical Center

address:
825 Erie Main St
Tonopah NV 89049

phone number:
775-482-6233

website:
www.nyeregional.org

certification:
CMS certified

bed count:
44

date of last inspection:
December 29, 2008

categories of services provided:

medical

surgical

acute, non-critical access

services provided:

- blood bank
- CT scanner
- emergency department (dedicated)
- emergency services
- laboratory – clinical
- magnetic resonance imaging
- outpatient services
- pharmacy
- physical therapy services
- radiology services – diagnostic
- respiratory care services
- urgent care center services

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Nye Regional Medical Center, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	0 total inspections	
deficiency	**frequency**	**regulation**
total deficiencies for this facility	**0**	

how to read this table:

This table shows the number of complaints received against Nye Regional Medical Center, including state or federal regulation status and whether they were substantiated.

COMPLAINTS (January 1, 2009 – December 31, 2009)	0 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	0	0	0
federal	0	0	0
total complaints for this facility	**0**	**0**	**0**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Nye Regional Medical Center, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	0 substantiated allegations	
allegation category	**sub-description**	**frequency**
total substantiated allegations for this facility		**0**

how to read this table:

This table shows the number of HACs that occurred at Nye Regional Medical Center, including a title and frequency for each condition as well as its CMS condition number.

HOSPITAL-ACQUIRED CONDITIONS (January 1, 2009 – December 31, 2009)	0 total HACs	
condition	**frequency**	**condition number**
foreign object retained after surgery	0	1
air embolism	0	2
blood incompatibility	0	3
stage III and IV pressure ulcers	0	4
falls and trauma	0	5
manifestations of poor glycemic control	0	6
catheter-associated urinary tract infection	0	7
vascular catheter-associated infection	0	8
surgical site infection following coronary artery bypass graft – mediastinitis	0	9A
surgical site infection following bariatric surgery	0	9B
surgical site infection following orthopedic procedures	0	9C
deep vein thrombosis/pulmonary embolism	0	10
total conditions for this facility	**0**	

Pershing General Hospital

address:
855 6th St
Lovelock NV 89419

phone number:
775-273-2621

website:
www.pershinghospital.org

certification:
CMS certified

bed count:
47

date of last inspection:
March 16, 2009

categories of services provided:

medical

surgical

services provided:

- blood bank
- CT scanner
- emergency services
- laboratory – clinical
- long term care (swing-beds)
- magnetic resonance imaging
- outpatient services
- pharmacy
- physical therapy services
- radiology services – diagnostic
- social services
- speech pathology services

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Pershing General Hospital, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	1 total inspection	
deficiency	**frequency**	**regulation**
total deficiencies for this facility	**1**	

how to read this table:

This table shows the number of complaints received against Pershing General Hospital, including state or federal regulation status and whether they were substantiated.

COMPLAINTS (January 1, 2009 – December 31, 2009)	1 total complaint		
complaint	**substantiated**	**unsubstantiated**	**other**
state	0	1	0
federal	0	0	0
total complaints for this facility	**0**	**0**	**0**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Pershing General Hospital, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	0 substantiated allegations	
allegation category	**sub-description**	**frequency**
total substantiated allegations for this facility		**0**

Pershing General Hospital's Response to the 2009 Annual Hospitals Report

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

Priority areas for Pershing General Hospital are Education of staff to healthcare-acquired infections, proper infection control procedures in all areas and the review and implementation of patient care policies.

2A: What is the short-term improvement plan (next 12 months)?

Short-Term Improvement Plan (next 12 months): Continue successful programs and processes currently in place such as our Quality Improvement and Infection Control Committees; continue participation in Nevada Rural Hospital Partners Risk Management Work Group; immediate review of infection control procedures in our central sterile area; review of policies; and certification of infection control staff.

2B: How will the organization measure success?

By observation of staff; survey results; and the number of policies updated.

3A: What is the long-term improvement plan (next 2-4 years)?

Long-Term Improvement Plan (next 2-4 years): Continue successful programs and processes currently in place such as our Quality Improvement and Infection Control Committees; continue participation in Nevada Rural Hospital Partners Risk Management Work Group; implement employee education program; certify infection control personnel; and develop a policy improvement team to keep policies and training up to date with all state and federal regulations. Expand the current infection control program at Pershing General Hospital.

3B: How will the organization measure success?

Survey results; observation; and chart review during the expanded infection control program.

4: Please give a statement of commitment:

Pershing General Hospital is committed to the improvement of quality of care and patient safety. Through education, policies, and regular meetings, we will strive to meet and or exceed the expectations for a small rural facility in Nevada. The proposed expansion of the patient safety and infection control programs will assist the facility to achieve this goal.

Progressive Hospital

address:
4015 McLeod Dr
Las Vegas NV 89121

phone number:
702-862-4002

website:
www.progressivehospital.com

certification:
CMS certified

bed count:
24

date of last inspection:
December 28, 2009

categories of services provided:

medical

services provided:

- dietetic service
- hospice
- laboratory – clinical
- occupational therapy service
- pharmacy
- physical therapy services
- radiology services – diagnostic
- respiratory care services
- rehab – inpatient (non-CARF)
- social services
- speech pathology services

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Progressive Hospital, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	3 total inspections	
deficiency	**frequency**	**regulation**
assessment of patient	1	NAC 449.3624
construction standards	1	NAC 449.3154
nursing service	1	NAC 449.361
personnel policies	3	NAC 449.363
pharmaceutical services	1	NAC 449.340
physical restraint use	2	NAC 449.3628
total deficiencies for this facility	**9**	

how to read this table:

This table shows the number of complaints received against Progressive Hospital, including state or federal regulation status and whether they were substantiated.

COMPLAINTS (January 1, 2009 – December 31, 2009)	1 total complaint		
complaint	**substantiated**	**unsubstantiated**	**other**
state	0	1	0
federal	0	0	0
total complaints for this facility	**0**	**1**	**0**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Progressive Hospital, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	0 substantiated allegations	
allegation category	**sub-description**	**frequency**
total substantiated allegations for this facility		**0**

Progressive Hospital's Response to the 2009 Annual Hospitals Report

In response to the following questions Progressive Hospital recognizes the need for the most up to date information and nationally recognized standards to improve our quality of care, staff communication, infection prevention and our patient safety. We strive to provide the best care and the safest patient environment and will use the following questions to reinforce our internal existing processes based upon nationally recognized guidelines as referenced below:

1. 2011 National Patient Safety Goals; The Joint Commission Accreditation Hospital
2. Institute for Health Care Improvement (IHI)
3. CDC: Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008; W. A. Rutala, Ph.D., M.P.H [1 2], D.J. Weber, M.D., M.P.H [1 2], and the Healthcare Infection Control Practices Advisory Committee (HICPAC) [3].
4. CDC: Management of Multidrug-Resistant Organisms in Healthcare Settings. 2006; J.D. Siegel, MD; E. Rhinehart, RN, M.P.H. CIC, M. Jackson, PhD; L. Chiarello, RN MS; and the Healthcare Infection Control Practices Advisory Committee (HICPAC)[3].
5. Prior Environmental Contamination increases the risk of acquisition of VRE. Clin Infect Dis, 2008 MAR 1; 46(5):678-85; Syndman, Schmid, Barefoot, Hansjosten, Vue, Nasraway and Golan.
6. Evaluation of an automated ultraviolet (UV) radiation device for decontamination of Clostridium Difficile and other healthcare-associated pathogens in hospital rooms; Nerandzic, Cadnum, Pultz and Donskey.

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

1) HAI prevention, 2) Present on admission (POA) data collection, 3) Better stewardship of antibiotics (ABX) use.

2A: What is the short-term improvement plan (next 12 months)?

1) Enhance patient/family education in regards to present infections and the use of hand washing, Personal Protective Equipment (PPE) and precautions to prevent HAI's. 2) Consider enhanced patient sampling of urine, urine analysis (UA), blood cultures, sputum cultures and at different sampling times and with different sampling techniques (combi cath) to establish POA data. 3) Use Internal Review Board (IRB) study of Virusolve+© to couple with enhanced UV light treatments to prevent HAI's through enhanced room cleaning. 4) Establish a PI team to collect weekly hand washing surveillance data.

2B: How will the organization measure success?

1) Monitoring and recording of staff, patient and family compliance with hand washing, PPE use, and infection control prevention practices. 2) Screening and review of new sampling practices and sampling times, to obtain objective data on POA infections. 3) IRB study results will give comparative data for analysis.

3A: What is the long-term improvement plan (next 2-4 years)?

1) Increase UV light cleaning and continue to follow up on IRB results, with possible Beta testing of Virusolve+©. 2) Aggressive POA differentiation and follow up with ID doctors to use data to target ABX delivery secondary to new delivery techniques and use time frames, gather POA data all within 72 hrs of admit. 3) Investigate new apparatus for room and hand culture sampling for better surveillance. 4) Look at enhancing two-way communication with the acute care Hospitals and SNF's regarding each patient's past infection history (currently treating and recently treated) and history of pathogen colonization. Progressive Hospital has already set up this communication format both verbally and with a new infection notification form to get similar infection history notification from the Hospitals and SNF's. This will allow us to better target treatment.

3B: How will the organization measure success?

1) Compare data from pre and post institution of new plan. 2) Utilize new sampling of rooms and data collected during IRB to come up with better IC practices. 3) Work with ID doctors to target POA cultures with optimal ABX. 4) enhance Infection Control (IC) reviews of patient infection history to establish past microbial colonization and infections and enhance lines of communication with other facilities to promote IC history sharing.

4: Please give a statement of commitment:

Progressive Hospital recognizes the need to provide a safe environment for its patients, staff and visitors and commits to provide the resources, organization and innovation to complete this task. We will continue to use the CDC, IHI, NPSGs (Joint Commission Accreditation Hospital), other nationally recognized organizations and publications to create and maintain our Hospital's practice standards, and to provide the safest environment for our patients, staff and visitors.

Red Rock Behavioral Hospital

address:
5975 W Twain Ave
Las Vegas NV 89103

phone number:
702-214-8099

website:
www.psysolutions.com/facilities/redrock/

accreditation:
The Joint Commission

bed count:
21

date of last inspection:
March 26, 2009

categories of services provided:

psychiatric

services provided:

- alcohol and/or drug services
- CT scanner
- dental service
- dietetic service
- gerontological specialty services
- laboratory – clinical
- magnetic resonance imaging
- pharmacy
- psychiatric services – emergency
- psychiatric – child/adolescent
- psychiatric – geriatric
- psychiatric – inpatient
- psychiatric – outpatient
- radiology services – diagnostic
- social services

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Red Rock Behavioral Hospital, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	2 total inspections	
deficiency	**frequency**	**regulation**
appropriate care of patient	1	NAC 449.3622
discharge planning	1	NAC 449.332
physical environment	1	NAC 449.316
total deficiencies for this facility	**3**	

how to read this table:

This table shows the number of complaints received against Red Rock Behavioral Hospital, including state or federal regulation status and whether they were substantiated.

COMPLAINTS (January 1, 2009 – December 31, 2009)	2 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	0	2	0
federal	0	0	0
total complaints for this facility	**0**	**2**	**0**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Red Rock Behavioral Hospital, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	0 substantiated allegations	
allegation category	**sub-description**	**frequency**
total substantiated allegations for this facility		**0**

Red Rock Behavioral Hospital's Response to the 2009 Annual Hospitals Report

Red Rock Behavioral Hospital has developed and implemented a well-defined, organized risk management program designed to ensure safety and enhance the quality of patient care. In our response Red Rock Behavioral Health Hospital recognizes the importance of providing safe, quality health care in a culture which promotes accountability and transparency, while utilizing this opportunity to reinforce existing internal processes based upon nationally recognized guidelines.

Our Performance Improvement Plan focuses on the important functions and processes of the organization to improve the quality of patient care, patient safety, and patient outcomes and to enhance the value of our services along with improving our operational efficiency.

The results of the 2009 report show two (2) inspections with 3 deficiencies and 2 complaints that were unsubstantiated. These deficiencies allowed us the opportunity to improve our processes. We implemented corrective action plans and have monitored our successful compliance.

With our focus on quality care, patient outcomes, and patient safety, we will continue to identify areas for improvement, gather data, implement corrective action plans where necessary and monitor compliance. This information is then presented at the Patient Safety Committee, Infection Control Committee, and Environment of Care Committee, as well as our Quality Council Committee, Medical Executive Committee, and Governing Board.

Red Rock Behavioral Hospital is committed to maintaining the achievements of our performance improvement activities and will continue to improve these processes and maintain compliance with ethical and regulatory standards.

Renown Regional Medical Center

address:
1155 Mill St
Reno NV 89502

phone number:
775-982-4511

website:
www.renown.org/regional/

accreditation:
The Joint Commission

bed count:
808

date of last inspection:
December 28, 2009

categories of services provided:

medical | surgical | obstetrical | acute, non-critical access

services provided:

- anesthesia
- blood bank
- cardiac catheterization laboratory
- cardiac – thoracic surgery
- chemotherapy service
- CT scanner
- dietetic service
- emergency department (dedicated)
- emergency services
- gerontological specialty services
- home health services
- ICU – cardiac (non-surgical)
- ICU – medical/surgical
- ICU – neonatal
- ICU – pediatric
- ICU – surgical
- laboratory – anatomical
- laboratory – clinical
- magnetic resonance imaging
- neonatal nursery
- neurosurgical services
- nuclear medicine services
- obstetric service
- occupational therapy service
- operating rooms
- opthalmic surgery
- outpatient services
- pediatric services
- pharmacy
- physical therapy services
- positron emission tomography
- post-operative recovery rooms
- psychiatric services – emergency
- psychiatric – child/adolescent
- psychiatric – outpatient
- radiology services – diagnostic
- radiology services – therapeutic
- reconstructive services
- respiratory care services
- rehab – outpatient
- renal dialysis (acute inpatient)
- social services
- speech pathology services
- surgical services – inpatient
- surgical services – outpatient
- trauma center (certified)
- urgent care center services

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Renown Regional Medical Center, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	10 total inspections	
deficiency	**frequency**	**regulation**
appropriate care of patient	1	NAC 449.3622
assessment of patient	2	NAC 449.3624
infections and communicable diseases	1	NAC 449.325
nursing service	1	NAC 449.361
total deficiencies for this facility	**5**	

how to read this table:

This table shows the number of complaints received against Renown Regional Medical Center, including state or federal regulation status and whether they were substantiated. The 1 other complaint was referred to another agency.

COMPLAINTS (January 1, 2009 – December 31, 2009)	18 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	5	11	1
federal	1	0	0
total complaints for this facility	**6**	**11**	**1**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Renown Regional Medical Center, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	7 substantiated allegations	
allegation category	**sub-description**	**frequency**
infection control		1
other services		1
quality of care/treatment		1
quality of care/treatment	other	1
resident/patient/client neglect	assess/monitor	1
resident/patient/client rights	access to resident/nursing home	1
restraints/seclusion – general		1
total substantiated allegations for this facility		**7**

how to read this table:

This table shows the number of HACs that occurred at Renown Regional Medical Center, including a title and frequency for each condition as well as its CMS condition number.

HOSPITAL-ACQUIRED CONDITIONS (January 1, 2009 – December 31, 2009)	81 total HACs	
condition	**frequency**	**condition number**
foreign object retained after surgery	2	1
air embolism	0	2
blood incompatibility	0	3
stage III and IV pressure ulcers	5	4
falls and trauma	13	5
manifestations of poor glycemic control	1	6
catheter-associated urinary tract infection	1	7
vascular catheter-associated infection	50	8
surgical site infection following coronary artery bypass graft – mediastinitis	0	9A
surgical site infection following bariatric surgery	1	9B
surgical site infection following orthopedic procedures	0	9C
deep vein thrombosis/pulmonary embolism	8	10
total conditions for this facility	**81**	

Renown Regional Medical Center's Response to the 2009 Annual Hospitals Report

Renown Regional Medical Center, a member of Renown Health, believes our purpose is to make a genuine difference for the many lives we touch by optimizing our patient's health care experience. Quality is one of our operating fundamentals, with our goal to provide excellence in care and to create a culture that promotes transparency and accountability. Process improvements, reflected herein, are based upon nationally recognized guidelines.

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

- Falls reduction and catheter-associated infection have been identified as areas of focus for improvement.

2A: What is the short-term improvement plan (next 12 months)?

Process improvements for Falls Reduction: Continue fall data collection, analysis and trending in concert with public reporting to the National Database of Nursing Quality Indicators (NDNQI) data base. Fall reduction activities will continue to focus on fall risk identification and proactive implementation of related risk reduction steps based upon evidence-based analysis.

Process improvements for Vascular Catheter-Associated Infections: Continued participation in the national Comprehensive Unit-based Safety Program (CUSP) to eliminate healthcare-acquired infections. Renown Regional Medical Center has implemented and follows the national blood stream infection reduction guidelines and has demonstrated dramatic improvements. Process improvements will be implemented on an interdisciplinary approach to ensure continuity in the application of quality improvement measures.

2B: How will the organization measure success?

Falls Reduction: To measure the effectiveness of the Hospital quality improvement initiatives the Hospital will report to and benchmark its performance based upon the NDNQI. All falls will be investigated to validate proper risk assessment and risk reduction steps implemented.

Vascular Catheter-Associated Infections: The hospital will follow National Healthcare Safety Network (NHSN) and CDC guidelines. All vascular catheter infections will be investigated to validate indwelling line protocols are followed with appropriate corrective steps to ensure compliance with protocols.

3A: What is the long-term improvement plan (next 2-4 years)?

Falls Reduction: The long-term Improvement plan includes achieving 100% adherence to fall reduction risk assessment processes validated by evidence-based data analysis. The hospital goal remains elimination of all preventable patient falls.

Vascular Catheter-Associated Infections: The long-term Improvement plan includes achieving 100% adherence to evidenced based practice vascular catheter care infection reduction processes validated by evidence-based data analysis. The hospital goal remains elimination of all vascular catheter-associated infections.

3B: How will the organization measure success?

Falls Reduction: The Hospital will continue to utilize NDNQI indicators along with its own surveillance data to assess and measure the effectiveness of performance improvement initiatives. The Hospital goal continues to be achievement of national Top 10% performance (0% falls).

Vascular Catheter-Associated Infections: The Hospital will utilize NHSN and CDC guidelines to assess and measure performance improvement efforts. The Hospital goal continues to be achievement of less than 1 infection per 1,000 device days.

4: Please give a statement of commitment:

Renown Regional Medical Center is committed to its guiding purpose: "to make a genuine difference for the many lives we touch by optimizing our patient's health care experience". We are dedicated to the Quality Fundamental to provide excellence in care and to create a culture that promotes transparency and accountability. Process improvements, reflected herein, are based upon nationally recognized guidelines.

The organization functions in a continuous quality improvement culture utilizing evidence-based improvement processes. Prospective and retrospective analysis of process is employed to achieve conformity with recognized Best Practices.

Renown Rehabilitation Hospital

address:
1495 Mill St
Reno NV 89502

phone number:
775-982-3500

website:
www.renown.org/rehabilitationlocation/

accreditation:
The Joint Commission
(under Renown Regional Medical Center)

bed count:
62

date of last inspection:
August 19, 2009

categories of services provided:

medical

services provided:

- dietetic service
- occupational therapy service
- outpatient services
- pharmacy
- physical therapy services
- radiology services – diagnostic
- radiology services – therapeutic
- respiratory care services
- rehab – inpatient (non-CARF)
- renal dialysis (acute inpatient)
- social services
- speech pathology services

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Renown Rehabilitation Hospital, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	3 total inspections	
deficiency	**frequency**	**regulation**
appropriate care of patient	4	NAC 449.3622
assessment of patient	1	NAC 449.3624
construction standards	1	NAC 449.3154
medical records	1	NAC 449.379
nursing services	1	NAC 449.361
outpatient services	1	NAC 449.370
pharmaceutical services	3	NAC 449.340
physical environment	2	NAC 449.316
sanitary conditions – supplies for food	3	NAC 449.3395
total deficiencies for this facility	**17**	

how to read this table:

This table shows the number of complaints received against Renown Rehabilitation Hospital, including state or federal regulation status and whether they were substantiated.

COMPLAINTS (January 1, 2009 – December 31, 2009)	2 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	2	0	0
federal	0	0	0
total complaints for this facility	**2**	**0**	**0**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Renown Rehabilitation Hospital, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	3 substantiated allegations	
allegation category	**sub-description**	**frequency**
quality of care/treatment		1
quality of care/treatment	care/service not received per physician's order	1
quality of care/treatment	other	1
total substantiated allegations for this facility		**3**

Renown Rehabilitation Hospital's Response to the 2009 Annual Hospitals Report

Renown Rehabilitation Hospital, a member of Renown Health, believes our purpose is to make a genuine difference for the many lives we touch by optimizing our patient's health care experience. Quality is one of our operating fundamentals, with our goal to provide excellence in care and to create a culture that promotes transparency and accountability. Process improvements, reflected herein, are based upon nationally recognized guidelines.

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

Falls Reduction

2A: What is the short-term improvement plan (next 12 months)?

Process improvements for Falls Reduction: Continue fall data collection and public reporting to the NDNQI data base. Fall reduction activities focus on fall risk identification and implementation of related risk reduction steps. Implementation of new patient call light technology.

The organization functions in a continuous quality improvement culture, and we also address any opportunities for improvement that we become aware of. We continually implement best practice in all areas as appropriate, not just those included in this report.

2B: How will the organization measure success?

Falls Reduction: Organization's fall occurrence data compared to NDNQI criteria. All falls investigated validate proper risk assessment and risk reduction steps implemented.

3A: What is the long-term improvement plan (next 2-4 years)?

Falls Reduction: 100% adherence to fall reduction processes with demonstrated reduction/elimination of all patient falls.

3B: How will the organization measure success?

Falls Reduction: NDNQI criteria. Goal: Achieve National Top 10% performance (0% falls).

4: Please give a statement of commitment:

Our purpose is to make a genuine difference for the many lives we touch by optimizing our patient's health care experience. We are dedicated to the Quality Fundamental to provide excellence in care and to create a culture that promotes transparency and accountability. Process improvements, reflected herein, are based upon nationally recognized guidelines.

The organization functions in a continuous quality improvement culture, and we also address any opportunities for improvement that we become aware of. We continually implement best practice in all areas as appropriate, not just those included in this report.

Renown South Meadows Medical Center

address:
10101 Double R Blvd
Reno NV 89521

phone number:
775-982-7000

website:
www.renown.org/southmeadows/

accreditation:
The Joint Commission

bed count:
76

date of last inspection:
October 19, 2009

categories of services provided:

medical

surgical

acute, non-critical access

services provided:

- anesthesia
- blood bank
- CT scanner
- dietetic service
- emergency department (dedicated)
- emergency services
- extracorporeal shock wave
- ICU – cardiac (non-surgical)
- ICU – medical/surgical
- ICU – surgical
- Laboratory – anatomical
- laboratory – clinical
- magnetic resonance imaging
- nuclear medicine services
- occupational therapy service
- operating rooms
- orthopedic surgery
- outpatient services
- pharmacy
- physical therapy services
- post-operative recovery rooms
- radiology services – diagnostic
- radiology services – therapeutic
- reconstructive services
- respiratory care services
- renal dialysis (acute inpatient)
- social services
- speech pathology services
- surgical services – inpatient
- surgical services – outpatient

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Renown South Meadows Medical Center, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	3 total inspections	
deficiency	**frequency**	**regulation**
appropriate care of patient	1	NAC 449.3622
surgical services	1	NAC 449.385
total deficiencies for this facility	**2**	

how to read this table:

This table shows the number of complaints received against Renown South Meadows Medical Center, including state or federal regulation status and whether they were substantiated.

COMPLAINTS (January 1, 2009 – December 31, 2009)	2 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	1	1	0
federal	0	0	0
total complaints for this facility	**1**	**1**	**0**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Renown South Meadows Medical Center, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	1 substantiated allegation	
allegation category	**sub-description**	**frequency**
quality of care/treatment	other	1
total substantiated allegations for this facility		**1**

how to read this table:

This table shows the number of HACs that occurred at Renown South Meadows Medical Center, including a title and frequency for each condition as well as its CMS condition number.

HOSPITAL-ACQUIRED CONDITIONS (January 1, 2009 – December 31, 2009)	18 total HACs	
condition	**frequency**	**condition number**
foreign object retained after surgery	0	1
air embolism	0	2
blood incompatibility	0	3
stage III and IV pressure ulcers	0	4
falls and trauma	9	5
manifestations of poor glycemic control	1	6
catheter-associated urinary tract infection	0	7
vascular catheter-associated infection	7	8
surgical site infection following coronary artery bypass graft – mediastinitis	0	9A
surgical site infection following bariatric surgery	0	9B
surgical site infection following orthopedic procedures	0	9C
deep vein thrombosis/pulmonary embolism	1	10
total conditions for this facility	**18**	

Renown South Meadows Medical Center's Response to the 2009 Annual Hospitals Report

Renown South Meadows Medical Center, a member of Renown Health, believes our purpose is to make a genuine difference for the many lives we touch by optimizing our patient's health care experience. Quality is one of our operating fundamentals, with our goal to provide excellence in care and to create a culture that promotes transparency and accountability. Process improvements, reflected herein, are based upon nationally recognized guidelines.

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

Falls Reduction

Vascular Catheter-Associated Infections

2A: What is the short-term improvement plan (next 12 months)?

Process improvements for Falls Reduction: Continue fall data collection and public reporting to the NDNQI data base. Fall reduction activities focus on fall risk identification and implementation of related risk reduction steps.

Process improvements for Vascular Catheter-Associated Infections: Continued participation, sponsored by the NHA and HealthInsight, in the national Comprehensive Unit-based Safety Program (CUSP) to eliminate healthcare acquired infections. Renown South Meadows has implemented and follows the national blood stream infection reduction guidelines and has demonstrated dramatic improvements.

The organization functions in a continuous quality improvement culture, and we also address any opportunities for improvement that we become aware of. We continually implement best practice in all areas as appropriate, not just those included in this report.

2B: How will the organization measure success?

Falls Reduction: Organization's fall occurrence data compared to NDNQI criteria. All falls investigated validate proper risk assessment and risk reduction steps implemented.

Vascular Catheter-Associated Infections: NHSN (National Healthcare Safety Network) and CDC guidelines. All vascular catheter infections investigated and validate indwelling line protocols followed.

3A: What is the long-term improvement plan (next 2-4 years)?

Falls Reduction: 100% adherence to fall reduction processes with demonstrated reduction/ elimination of all patient falls.

Vascular Catheter-Associated Infections: 100% adherence to evidenced based practice vascular catheter care infection reduction processes.

3B: How will the organization measure success?

Falls Reduction: NDNQI criteria. Goal: Achieve National Top 10% performance (0% falls).

Vascular Catheter-Associated Infections: NHSN (National Healthcare Safety Network) and CDC guidelines. Goal: Achieve less than 1 infection per 1,000 device days.

4: Please give a statement of commitment:

Our purpose is to make a genuine difference for the many lives we touch by optimizing our patient's health care experience. We are dedicated to the Quality Fundamental to provide excellence in care and to create a culture that promotes transparency and accountability. Process improvements, reflected herein, are based upon nationally recognized guidelines.

The organization functions in a continuous quality improvement culture, and we also address any opportunities for improvement that we become aware of. We continually implement best practice in all areas as appropriate, not just those included in this report.

Saint Mary's Regional Medical Center

address:
235 W 6th St
Reno NV 89503

phone number:
775-770-3000

website:
www.saintmarysreno.org

accreditation:
The Joint Commission

bed count:
380

date of last inspection:
July 16, 2009

categories of services provided:

medical | surgical | obstetrical | acute, non-critical access

services provided:

- anesthesia
- blood bank
- cardiac catheterization laboratory
- cardiac – thoracic surgery
- chemotherapy service
- CT scanner
- dietetic service
- emergency department (dedicated)
- emergency services
- extracorporeal shock wave
- hospice
- ICU – cardiac (non-surgical)
- ICU – medical/surgical
- ICU – neonatal
- ICU – surgical
- laboratory – anatomical
- laboratory – clinical
- magnetic resonance imaging
- neonatal nursery
- neurosurgical services
- nuclear medicine services
- obstetric service
- occupational therapy service
- operating rooms
- opthalmic surgery
- orthopedic surgery
- outpatient services
- pediatric services
- pharmacy
- physical therapy services
- positron emission tomography
- post-operative recovery rooms
- radiology services – diagnostic
- radiology services – therapeutic
- reconstructive services
- respiratory care services
- renal dialysis (acute inpatient)
- social services
- speech pathology services
- surgical services – inpatient
- surgical services – outpatient

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Saint Mary's Regional Medical Center, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	2 total inspections	
deficiency	**frequency**	**regulation**
total deficiencies for this facility	**0**	

how to read this table:

This table shows the number of complaints received against Saint Mary's Regional Medical Center, including state or federal regulation status and whether they were substantiated. No action was necessary for the 1 other complaint.

COMPLAINTS (January 1, 2009 – December 31, 2009)	6 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	1	3	1
federal	1	0	0
total complaints for this facility	**2**	**3**	**1**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Saint Mary's Regional Medical Center, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	3 substantiated allegations	
allegation category	**sub-description**	**frequency**
physical environment	facility not clean	1
physical environment	safe environment not provided	1
resident/patient/client rights	failed to acquire informed consent	1
total substantiated allegations for this facility		**3**

how to read this table:

This table shows the number of HACs that occurred at Saint Mary's Regional Medical Center, including a title and frequency for each condition as well as its CMS condition number.

HOSPITAL-ACQUIRED CONDITIONS (January 1, 2009 – December 31, 2009)	40 total HACs	
condition	**frequency**	**condition number**
foreign object retained after surgery	1	1
air embolism	0	2
blood incompatibility	0	3
stage III and IV pressure ulcers	2	4
falls and trauma	3	5
manifestations of poor glycemic control	1	6
catheter-associated urinary tract infection	5	7
vascular catheter-associated infection	25	8
surgical site infection following coronary artery bypass graft – mediastinitis	0	9A
surgical site infection following bariatric surgery	1	9B
surgical site infection following orthopedic procedures	1	9C
deep vein thrombosis/pulmonary embolism	1	10
total conditions for this facility	**40**	

Saint Mary's Regional Medical Center's Response to the 2009 Annual Hospitals Report

As a leader in the provision of quality health care in northern Nevada, Saint Mary's recognizes the importance of providing our patients safe and quality health care. We embody a culture that promotes accountability and transparency, and will use the 2009 Nevada Hospital Report as an opportunity to reinforce our existing internal processes, based upon nationally recognized guidelines as referenced below.

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

<no specific response>

2A: What is the short-term improvement plan (next 12 months)?

Because patient safety is so important, Saint Mary's encourages national and statewide agencies to develop a core set of quality measures for health care organizations. Additionally, we are committed to improving patient care nationwide and will work with all partnering organizations to develop new processes that will result in safer patient care. During the next 12 months, Saint Mary's will be focusing on two opportunities for improvement – patient falls and vascular catheter-associated infections.

Saint Mary's already has an established patient fall committee, which has recently adopted the widely acclaimed Johns Hopkins fall standards. Furthermore, Saint Mary's is an active participant in the 2011 Institute for Healthcare Improvement's (IHI) patient fall prevention initiative. With the IHI's guidance, Saint Mary's will be adopting fall prevention recommendations from some of the leading experts in patient fall prevention.

Saint Mary's is very proud of its work over the last two years in preventing vascular catheter-associated infections. Saint Mary's has remained in compliance with National Patient Safety Goals and the "CUSP" Program (a comprehensive safety program developed by Johns Hopkins) and carefully monitors and takes all necessary precautions to avoid infection and the spread of disease, particularly in vulnerable patients with catheters and central lines.

2B: How will the organization measure success?

Saint Mary's makes patient care and safety the number-1 priority, which is why we support public reporting of hospital data. We remain transparent and honest about our hospital data and strive to improve our quality measures, guaranteeing our patients are healthy and safe.

To help our patients remain safe, Saint Mary's will measure its success in reducing patient falls by complying with IHI best practice guidelines and continuing to reduce patient fall rates from previous years. With regard to reducing vascular catheter-associated infections, Saint Mary's measures its success against the benchmarks within NHSN. The NHSN is the national standard and establishes the benchmark by which all hospitals measure their performance. Through vigilant surveillance, education about central line-associated infection prevention, standardization of protocols and monitoring, and implementation of policies and practices aimed at reducing the risk of infection, Saint Mary's has had no vascular catheter-associated infections in the adult critical care unit from March 2009 to September 2010 and absolutely no infections in the neonatal intensive care unit since March 2008. Saint Mary's is currently performing at the best practice benchmark as established by the NHSN.

3A: What is the long-term improvement plan (next 2-4 years)?

It is essential for hospitals both locally and nationally to monitor quality ratings and have initiatives focused on patient safety. Saint Mary's Regional Medical Center is committed to preventing occurrences of HACs, and as a leader in quality health care in northern Nevada, subscribes to and complies with all National Patient Safety Goals in addition to numerous patient safety and quality improvement programs. Our long-term improvement plan is to maintain our leadership in the provision of quality health care in northern Nevada by meeting and exceeding all National Patient Safety Goals, achieving Top 10% in the nation status in the provision of CMS' core measures, and the prevention of all HACs.

3B: How will the organization measure success?

At Saint Mary's we measure our quality performance against the very best hospitals in the nation. We are constantly striving to prevent HACs from ever happening. As an organization, Saint Mary's measures its success by achieving performance comparable to the Top 10% of hospitals in the nation. Saint Mary's has identified some opportunities to improve our CMS core measure scores and will move our core measure indicators into the Top 10% of hospitals. Additionally, Saint Mary's will improve our National Patient Safety Goal performance from our previous scores as we work closely with our corporate NPSG consultants to improve our performance and provide our patients with the safest quality of care possible.

4: Please give a statement of commitment:

Saint Mary's is a leading health care provider in northern Nevada and is committed to improving and maintaining the highest level of quality of care for our patients. At Saint Mary's, patient safety is a top priority and we take significant steps to prevent and reduce potential risks and infections. These efforts include committees to address and review every HAC category, carefully tracking and monitoring our performance, instituting vigilant surveillance in critical care areas, reviewing and updating hospital systems and procedures continuously, and providing comprehensive education and prevention strategies to all physicians, nurses, and staff, in addition to patients and their families.

Seven Hills Behavioral Institute

address:
3021 W Horizon Ridge Pkwy
Henderson NV 89052

phone number:
702-646-5000

website:
www.sevenhillsbi.com

accreditation:
The Joint Commission

bed count:
55

date of last inspection:
August 17, 2009

categories of services provided:

psychiatric

services provided:

- alcohol and/or drug services
- psychiatric – emergency
- psychiatric – child/adolescent
- psychiatric – geriatric
- psychiatric – inpatient

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Seven Hills Behavioral Institute, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	4 total inspections	
deficiency	**frequency**	**regulation**
emergency laboratory services	1	482.27(a)(1)
life safety code standard	1	NFPA 101
medical staff	1	482.62(b)(2)
nursing care plan	1	482.23(b)(4)
nursing services	1	482.62(d)(1)
nursing services	1	482.62(d)(2)
personnel policies	1	NAC 449.363
pharmacist responsibilities	1	482.25(a)(1)
policies for laboratory services	1	482.27(a)(4)
QAPI program scope	1	482.21(a)
qualified staff	1	482.26(c)(2)
specific medical record requested for psychiatric hospitals	1	482.61
staff education	1	482.45(a)(5)
staffing and delivery of care	1	482.23(b)
tissue and eye bank agreements	1	482.45(a)(2)
treatment plan	2	482.61(c)(1)
treatment plan	1	482.61(c)(1)(ii)
treatment plan	1	482.61(c)(1)(iii)
treatment plan	1	482.61(c)(1)(iv)
treatment plan	1	482.61(c)(2)
unusable drugs not used	1	482.25(b)(3)
written protocol for tissue specimens	1	482.27(a)(3)
total deficiencies for this facility	**23**	

how to read this table:

This table shows the number of complaints received against Seven Hills Behavioral Institute, including state or federal regulation status and whether they were substantiated.

COMPLAINTS (January 1, 2009 – December 31, 2009)	2 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	1	1	0
federal	0	0	0
total complaints for this facility	**1**	**1**	**0**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Seven Hills Behavioral Institute, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	1 substantiated allegation	
allegation category	**sub-description**	**frequency**
physical environment	facility not clean	1
total substantiated allegations for this facility		**1**

Sierra Surgery Hospital

address:
1400 Medical Pkwy
Carson City NV 89703

phone number:
775-883-1700

website:
www.sierrasurgery.com

accreditation:
The Joint Commission

bed count:
15

date of last inspection:
August 25, 2009

categories of services provided:

surgical

acute, non-critical access

services provided:

- anesthesia
- blood bank
- CT scanner
- dental service
- dietetic service
- extracorporeal shock wave
- laboratory – clinical
- magnetic resonance imaging
- neurosurgical services
- occupational therapy service
- operating rooms
- opthalmic surgery
- orthopedic surgery
- outpatient services
- pharmacy
- physical therapy services
- post-operative recovery rooms
- radiology services – diagnostic
- reconstructive services
- respiratory care services
- social services
- surgical services – inpatient
- surgical services – outpatient

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Sierra Surgery Hospital, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	1 total inspection	
deficiency	**frequency**	**regulation**
total deficiencies for this facility	**0**	

how to read this table:

This table shows the number of complaints received against Sierra Surgery Hospital, including state or federal regulation status and whether they were substantiated.

COMPLAINTS (January 1, 2009 – December 31, 2009)	1 total complaint		
complaint	**substantiated**	**unsubstantiated**	**other**
state	1	0	0
federal	0	0	0
total complaints for this facility	**1**	**0**	**0**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Sierra Surgery Hospital, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	1 substantiated allegation	
allegation category	**sub-description**	**frequency**
resident/patient/client rights	billing	1
total substantiated allegations for this facility		**1**

how to read this table:

This table shows the number of HACs that occurred at Sierra Surgery Hospital, including a title and frequency for each condition as well as its CMS condition number.

HOSPITAL-ACQUIRED CONDITIONS (January 1, 2009 – December 31, 2009)	0 total HACs	
condition	**frequency**	**condition number**
foreign object retained after surgery	0	1
air embolism	0	2
blood incompatibility	0	3
stage III and IV pressure ulcers	0	4
falls and trauma	0	5
manifestations of poor glycemic control	0	6
catheter-associated urinary tract infection	0	7
vascular catheter-associated infection	0	8
surgical site infection following coronary artery bypass graft – mediastinitis	0	9A
surgical site infection following bariatric surgery	0	9B
surgical site infection following orthopedic procedures	0	9C
deep vein thrombosis/pulmonary embolism	0	10
total conditions for this facility	**0**	

Sierra Surgery Hospital's Response to the 2009 Annual Hospitals Report

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

Sierra Surgery Hospital had one complaint in 2009. The problem occurred when a drug manufacturer changed the color of the top of the medication vial. The hospital's process for handling look-alike, sound-alike medications was changed because of an error in medication administration.

2A: What is the short-term improvement plan (next 12 months)?

Since the change in the process of handling look-alike, sound-alike medications, the problem has been resolved.

2B: How will the organization measure success?

The hospital performance improvement committee reviews all medication misadventures, and monitors the medication management process. The focus is on patient safety.

3A: What is the long-term improvement plan (next 2-4 years)?

The hospital will be implementing bar coding for medication administration with our electronic health record in the next year to year and a half. This will provide another safety measure to keep patients safe during medication administration, making sure the right patient, right drug, right route are confirmed.

3B: How will the organization measure success?

If this medication error does not occur again, it will be considered a success. The performance improvement committee and the Quality Committee review all medication errors that occur.

4: Please give a statement of commitment:

Sierra Surgery Hospital is committed to providing the highest level of quality to patients who choose to have surgery and imaging services at our hospital.

South Lyon Medical Center

address:
213 Whitacre St
Yerington NV 89447

phone number:
775-463-2301

website:
www.southlyonmedicalcenter.org

certification:
CMS certified

bed count:
63

date of last inspection:
October 31, 2008

categories of services provided:

medical

surgical

acute, non-critical access

services provided:

- blood bank
- CT scanner
- emergency services
- laboratory – clinical
- long term care (swing-beds)
- outpatient services
- physical therapy services
- radiology services – diagnostic
- respiratory care services
- rehab – outpatient
- social services
- urgent care center services

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at South Lyon Medical Center, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	0 total inspections	
deficiency	**frequency**	**regulation**
total deficiencies for this facility	**0**	

how to read this table:

This table shows the number of complaints received against South Lyon Medical Center, including state or federal regulation status and whether they were substantiated.

COMPLAINTS (January 1, 2009 – December 31, 2009)	0 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	0	0	0
federal	0	0	0
total complaints for this facility	**0**	**0**	**0**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against South Lyon Medical Center, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	0 substantiated allegations	
allegation category	**sub-description**	**frequency**
total substantiated allegations for this facility		**0**

how to read this table:

This table shows the number of HACs that occurred at South Lyon Medical Center, including a title and frequency for each condition as well as its CMS condition number.

HOSPITAL-ACQUIRED CONDITIONS (January 1, 2009 – December 31, 2009)	0 total HACs	
condition	**frequency**	**condition number**
foreign object retained after surgery	0	1
air embolism	0	2
blood incompatibility	0	3
stage III and IV pressure ulcers	0	4
falls and trauma	0	5
manifestations of poor glycemic control	0	6
catheter-associated urinary tract infection	0	7
vascular catheter-associated infection	0	8
surgical site infection following coronary artery bypass graft – mediastinitis	0	9A
surgical site infection following bariatric surgery	0	9B
surgical site infection following orthopedic procedures	0	9C
deep vein thrombosis/pulmonary embolism	0	10
total conditions for this facility	**0**	

Southern Hills Hospital and Medical Center

address:
9300 W Sunset Rd
Las Vegas NV 89148

phone number:
702-880-2100

website:
www.southernhillshospital.com

accreditation:
The Joint Commission

bed count:
139

date of last inspection:
November 30, 2009

categories of services provided:

medical | surgical | obstetrical | acute, non-critical access

services provided:

- anesthesia
- blood bank
- cardiac catheterization laboratory
- CT scanner
- dietetic service
- emergency services
- ICU – medical/surgical
- ICU – neonatal
- laboratory – anatomical
- laboratory – clinical
- magnetic resonance imaging
- neonatal nursery
- neurosurgical services
- nuclear medicine services
- obstetric service
- occupational therapy service
- operating rooms
- orthopedic surgery
- outpatient services
- pediatric services
- pharmacy
- physical therapy services
- post-operative recovery rooms
- radiology services – diagnostic
- radiology services – therapeutic
- respiratory care services
- renal dialysis (acute inpatient)
- social services
- speech pathology services
- surgical services – inpatient
- surgical services – outpatient

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Southern Hills Hospital and Medical Center, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	3 total inspections	
deficiency	**frequency**	**regulation**
admission of patients	1	NAC 449.329
discharge planning	4	NAC 449.332
total deficiencies for this facility	**5**	

how to read this table:

This table shows the number of complaints received against Southern Hills Hospital and Medical Center, including state or federal regulation status and whether they were substantiated. The 1 other complaint was referred to another agency.

COMPLAINTS (January 1, 2009 – December 31, 2009)	11 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	4	6	1
federal	0	0	0
total complaints for this facility	**4**	**6**	**1**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Southern Hills Hospital and Medical Center, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	4 substantiated allegations	
allegation category	**sub-description**	**frequency**
admission, transfer, and discharge rights		1
quality of care/treatment	other	1
quality of care/treatment	resident medications not given according to physician instructions	1
resident/patient/client neglect	pressure sores	1
total substantiated allegations for this facility		**4**

how to read this table:

This table shows the number of HACs that occurred at Southern Hills Hospital and Medical Center, including a title and frequency for each condition as well as its CMS condition number.

HOSPITAL-ACQUIRED CONDITIONS (January 1, 2009 – December 31, 2009)	16 total HACs	
condition	**frequency**	**condition number**
foreign object retained after surgery	0	1
air embolism	0	2
blood incompatibility	0	3
stage III and IV pressure ulcers	3	4
falls and trauma	6	5
manifestations of poor glycemic control	0	6
catheter-associated urinary tract infection	2	7
vascular catheter-associated infection	2	8
surgical site infection following coronary artery bypass graft – mediastinitis	0	9A
surgical site infection following bariatric surgery	0	9B
surgical site infection following orthopedic procedures	0	9C
deep vein thrombosis/pulmonary embolism	3	10
total conditions for this facility	**16**	

Southern Hills Hospital and Medical Center's Response to the 2009 Annual Hospitals Report

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

Top three priorities consist of eliminating healthcare-associated infections (HAI), reducing hospital-acquired conditions (HAC) and implementing an electronic health record.

2A: What is the short-term improvement plan (next 12 months)?

Southern Hills Hospital is participating in the Comprehensive Unit-based Safety Program (CUSP) model, which was developed by the Johns Hopkins Quality and Safety Research Group. This model was first used in the Keystone Project, along with CLABSI elimination protocols, and is estimated to have saved 1,200 lives per year and reduced costs by $175 million annually. The CUSP model is now a national collaborative funded by AHRQ. As an adjunct to CUSP, Sunrise Hospital has launched an internal initiative called Aim for Zero Campaign. This campaign expands on the insertion bundle that Dr. Peter Pronovost developed in the Keystone Project and adds a second unique bundle focusing on maintenance of central lines. The goal of these projects is to eliminate CLABSIs.

Southern Hills is working on a collaborative with the Institute for Healthcare Improvement (IHI), an independent not-for-profit organization helping to lead the improvement of health care throughout the world. This program is built on our bold commitment to improve the patient experience and achieves the following objectives: engage leadership in improving the patient experience; develop and build a culture focused on quality improvement and patient-centered care; and realize new levels of patient experience in the areas of communication with the care team (including nursing), cleanliness, and pain management.

2B: How will the organization measure success?

HAI, HAC, Sentinel Events and HCAHPS data will all indicate if improvement is achieved.

3A: What is the long-term improvement plan (next 2-4 years)?

By 2015, Southern Hills Hospital will implement a fully integrated Electronic Health Record (EHR). An EHR is a secure, real-time, point-of-care, patient-centric information resource for clinicians. The EHR aids clinicians' decision-making by providing access to patient health record information where and when they need it and by incorporating evidence-based decision support. The EHR automates and streamlines the clinician's workflow, closing loops in communication and response that result in delays or gaps in care. The EHR also supports the collection of data for uses other than direct clinical care, such as billing, quality management, outcomes reporting, resource planning, and public health disease surveillance and reporting (HIMSS). It is our belief that the EHR will be one of the most fundamental support systems for optimizing the safety, quality, effectiveness and efficiency of healthcare that we provide in our facility.

3B: How will the organization measure success?

By accomplishing Stages I, II and III of Meaningful Use set by the HITECH Act.

4: Please give a statement of commitment:

Our initiatives harmonize with the best practice recommendations set forth by the NQF's Safe Practices and The Joint Commission's standards. We collaborate with local and national patient safety organizations, including NHA Patient Safety Committee; the Southern Nevada Health District; HealthInsight; the Institute for Safe Medication Practices; the Institute for Healthcare Improvement; the Leapfrog Group; and the National Patient Safety Foundation, all in an effort to ensure a safe environment and experience for our patients, staff and physicians.

Southern Nevada Adult Mental Health Services

address:
6161 W Charleston Blvd
Las Vegas NV 89146

phone number:
702-486-6000

website:
mhds.nv.gov/index.php?option=com_content&task=view&id=61&Itemid=69

accreditation:
The Joint Commission

bed count:
289

date of last inspection:
December 11, 2009

categories of services provided:

psychiatric

services provided:

- dietetic service
- laboratory – clinical
- pharmacy
- psychiatric services – emergency
- psychiatric – inpatient
- psychiatric – outpatient
- social services

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Southern Nevada Adult Mental Health Services, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	10 total inspections	
deficiency	**frequency**	**regulation**
administration of drugs	1	482.23(c)
infection control officer responsibilities	2	482.42(a)(1)
life safety code standard	13	NFPA 101
patient rights	1	482.13
patient rights: grievance procedures	1	482.13(a)(2)(i)
patient rights: grievance review time frames	1	482.13(a)(2)(ii)
patient rights: grievances	1	482.13(a)(2)
patient rights: review of grievances	1	482.13(a)(2)
patient rights: timely referral of grievances	1	482.13(a)(2)
policies for laboratory services	1	482.27(a)(4)
quality of care	1	NAC 449.314
total deficiencies for this facility	**24**	

how to read this table:

This table shows the number of complaints received against Southern Nevada Adult Mental Health Services, including state or federal regulation status and whether they were substantiated. No action was necessary for the 1 other complaint.

COMPLAINTS (January 1, 2009 – December 31, 2009)	12 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	1	9	1
federal	0	1	0
total complaints for this facility	**1**	**10**	**1**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Southern Nevada Adult Mental Health Services, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	1 substantiated allegation	
allegation category	**sub-description**	**frequency**
resident/patient/client abuse	sexual	1
total substantiated allegations for this facility		**1**

Southern Nevada Adult Mental Health Services' Response to the 2009 Annual Hospitals Report

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

Southern Nevada Adult Mental Health Services (SNAMHS) has identified the following priority areas:

- Life Safety Codes for all buildings in which patient services are delivered;
- Patient Rights and Safety; and
- Infection Control and Prevention.

2A: What is the short-term improvement plan (next 12 months)?

SNAMHS Organizational Safety Plan is the combination of both the SNAMHS Safety Plan and the SNAMHS Patient Safety Plan which are designed and coordinated to achieve safety for patients, employees and visitors. The SNAMHS Patient Safety Team has been assigned the responsibility to review, analyze, report and follow up.

A. SNAMHS' objectives to improve quality of care and patient safety for fiscal year 2011 shall be:
    1. The Patient Safety Team members shall review literature and evidence-based practices relating to patient safety.
    2. The Patient Safety Team shall update the patient safety plan for fiscal year 2012 and annually thereafter.
    3. The Patient Safety Team shall receive and review the Environment of Care Team's annual review and supporting documentation of environmental rounds and reviews of the seven life safety plans of 2010 and the goals for the upcoming year.
    4. The Patient Safety Team shall receive and review the Infection Control Team's annual risk assessment infection prevention plan and the goals for the upcoming year.
    5. The Patient Safety Team shall develop and design activities to improve the reporting of patient safety incidents by employees to the Patient Safety Officer.
    6. Medical Staff Initiative – The medical staff shall develop and design activities to reduce aggressive and assaultive behaviors by patients towards employees and other patients by:
        a) Proactively educating patients of the real consequences to include reporting to police;
        b) Proactively educating and supporting employees to report real and potential concerns and encourage reporting of real events to the police;
        c) Investigating and collaborating with local law enforcement to reduce the stigma associated with individuals who are diagnosed with mental illness;
        d) Investigate the potential for and impact of visual signs discouraging violence and weapons; and
        e) Proactively communicating with employees follow up and progress associated with events.
    7. Nursing Leadership Initiatives:
        a) Improve the efficiency and effectiveness of Dr. Blue Code drills.

b) Improve the efficiency of seclusion and/or restraint transports, event and documentation.

c) Decrease the number and severity of patient falls.

d) Reduce and potentially eliminate the use of four and five point restraints.

8. Agency –wide Initiative:

a) Enhance fire and emergency evacuation drills by maintenance department;

b) Improve agency safety culture by encouraging the reporting and follow up of patient safety concerns and events; and

c) Improve agency safety culture by encouraging the reporting and repair of unsafe equipment.

2B: How will the organization measure success?

SNAMHS will measure success by the documented submission, review, analysis, and follow up relating to:

A. Annual patient safety plan, goals and objectives;
B. Annual environment of care plans, goals and objectives; and
C. Annual infection prevention plans, goals and objectives.

SNAMHS will monitor the count and consequential intensity of the following events and would expect a reduction:

A. Events involving assaults and/or injuries by and to patients;
B. Seclusion and/or restraint events; and
C. Events involving patient falls and consequential injuries.

SNAMHS will monitor the count of the following events and would expect an increase:

A. Reports relating to safety concerns.

3A: What is the long-term improvement plan (next 2-4 years)?

SNAMHS will continue the annual review and update of the:

1. The patient safety plan and goals;
2. The Environment of Care Team's plan and goals; and
3. The Infection Control Team's annual risk assessment, plan and goals.
4. Safety Initiatives plans from:
   a. Medical Staff;
   b. Nursing Staff; and
   c. SNAMHS Departments.

3B: How will the organization measure success?

SNAMHS will measure success as demonstrated by the reduction in or absence of the count of substantiated complaints received and investigated by licensing, accrediting and certifying bodies.

SNAMHS also will monitor the count of sentinel events involving patients and expect the reduction or the absence of such.

4: Please give a statement of commitment:

A. Quality and safety in delivering services are valued at SNAMHS.

B. A culture of safety is an atmosphere of mutual trust in which all staff members, patients and visitors can report and talk freely about safety problems and how to solve them, without fear of blame or punishment.

C. The primary responsibility of leaders is to provide for the safety and quality of care, treatment, and services. The way the leaders interact with each other and manage their assigned accountabilities affects patient outcomes. Leaders shape SNAMHS' culture, and the culture, in turn, affects how the SNAMHS organization accomplishes its work. A healthy, thriving culture is built around the mission and vision, which reflect the core values and principles that the leaders find important. The safety and quality of care, treatment, and services depend on many factors including the following:

    1. A culture that fosters safety as a priority for everyone who works in the organization;
    2. The planning and provision of services that meet the needs of patients;
    3. The availability of resources—human, financial, and physical—for providing care, treatment, and services;
    4. The existence of competent staff and other care providers; and
    5. Ongoing evaluation of and improvement in performance.

Spring Mountain Sahara

address:
5460 W Sahara Ave
Las Vegas NV 89146

phone number:
702-873-2400

website:
www.springmountainsahara.com

accreditation:
The Joint Commission
(under Spring Mountain Treatment Center)

bed count:
30

date of last inspection:
May 11, 2009

categories of services provided:

psychiatric

services provided:

- alcohol and/or drug services
- anesthesia
- audiology
- CT scanner
- dental service
- dietetic service
- emergency services
- laboratory – clinical
- occupational therapy services
- organ bank
- organ transplant services
- pharmacy
- physical therapy services
- psychiatric services – emergency
- psychiatric – geriatric
- psychiatric – inpatient
- psychiatric – outpatient
- radiology services – diagnostic
- social services
- speech pathology services

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Spring Mountain Sahara, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	1 total inspection	
deficiency	**frequency**	**regulation**
total deficiencies for this facility	**0**	

how to read this table:

This table shows the number of complaints received against Spring Mountain Sahara, including state or federal regulation status and whether they were substantiated.

COMPLAINTS (January 1, 2009 – December 31, 2009)	0 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	0	0	0
federal	0	0	0
total complaints for this facility	**0**	**0**	**0**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Spring Mountain Sahara, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	0 substantiated allegations	
allegation category	**sub-description**	**frequency**
total substantiated allegations for this facility		**0**

Spring Mountain Sahara's Response to the 2009 Annual Hospitals Report

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

The hospital is committed to a high standard of patient safety and treatment.

2A: What is the short-term improvement plan (next 12 months)?

Patient safety and treatment

2B: How will the organization measure success?

Through quality indicators as required by The Joint Commission and CMS

3A: What is the long-term improvement plan (next 2-4 years)?

Patient safety and treatment

3B: How will the organization measure success?

Through quality indicators as required by The Joint Commission and CMS

4: Please give a statement of commitment:

Spring Mountain Treatment Center will maintain the mission and vision of the hospital and regulatory requirements.

Spring Mountain Treatment Center

address:
7000 W Spring Mountain Rd
Las Vegas NV 89117

phone number:
702-873-2400

website:
www.springmountaintreatmentcenter.com

accreditation:
The Joint Commission

bed count:
82

date of last inspection:
October 23, 2009

categories of services provided:

psychiatric

services provided:

- alcohol and/or drug services
- audiology
- CT scanner
- dental service
- dietetic service
- emergency services
- laboratory – clinical
- occupational therapy services
- organ bank
- organ transplant services
- pharmacy
- physical therapy services
- psychiatric services – emergency
- psychiatric – child/adolescent
- psychiatric – inpatient
- psychiatric – outpatient
- radiology services – diagnostic
- social services
- speech pathology services

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Spring Mountain Treatment Center, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	3 total inspections	
deficiency	**frequency**	**regulation**
total deficiencies for this facility	**0**	

how to read this table:

This table shows the number of complaints received against Spring Mountain Treatment Center, including state or federal regulation status and whether they were substantiated.

COMPLAINTS (January 1, 2009 – December 31, 2009)	3 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	2	1	0
federal	0	0	0
total complaints for this facility	**2**	**1**	**0**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Spring Mountain Treatment Center, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	2 substantiated allegations	
allegation category	**sub-description**	**frequency**
dietary services	food not palatable	1
other		1
total substantiated allegations for this facility		**2**

Spring Mountain Treatment Center's Response to the 2009 Annual Hospitals Report

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

The hospital is committed to a high standard of patient safety and treatment.

2A: What is the short-term improvement plan (next 12 months)?

Patient safety and treatment

2B: How will the organization measure success?

Through quality indicators as required by The Joint Commission and CMS

3A: What is the long-term improvement plan (next 2-4 years)?

Patient safety and treatment

3B: How will the organization measure success?

Through quality indicators as required by The Joint Commission and CMS

4: Please give a statement of commitment:

Spring Mountain Treatment Center will maintain the mission and vision of the hospital and regulatory requirements.

Spring Valley Hospital Medical Center

address:
5400 S Rainbow Blvd
Las Vegas NV 89118

phone number:
702-853-3000

website:
www.springvalleyhospital.com

accreditation:
The Joint Commission

average annual bed count:
230

date of last inspection:
September 21, 2009

categories of services provided:


medical


surgical


obstetrical


acute, non-critical access

services provided:

- anesthesia
- cardiac catheterization laboratory
- cardiac – thoracic surgery
- chemotherapy service
- CT scanner
- dental service
- dietetic service
- emergency department (dedicated)
- emergency services
- ICU – medical/surgical
- ICU – neonatal
- ICU – surgical
- laboratory – anatomical
- laboratory – clinical
- magnetic resonance imaging
- neonatal nursery
- neurosurgical services
- nuclear medicine services
- obstetric service
- occupational therapy service
- operating rooms
- orthopedic surgery
- outpatient services
- pharmacy
- physical therapy services
- post-operative recovery rooms
- psychiatric services – emergency
- radiology services – diagnostic
- radiology services – therapeutic
- reconstructive services
- respiratory care services
- rehab – inpatient (non-CARF)
- renal dialysis (acute inpatient)
- social services
- speech pathology services
- surgical services – inpatient
- surgical services – outpatient
- urgent care center services

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Spring Valley Hospital Medical Center, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	5 total inspections	
deficiency	**frequency**	**regulation**
appropriate care of patient	1	NAC 449.3622
total deficiencies for this facility	**1**	

how to read this table:

This table shows the number of complaints received against Spring Valley Hospital Medical Center, including state or federal regulation status and whether they were substantiated.

COMPLAINTS (January 1, 2009 – December 31, 2009)	7 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	3	4	0
federal	0	0	0
total complaints for this facility	**3**	**4**	**0**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Spring Valley Hospital Medical Center, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	4 substantiated allegations	
allegation category	**sub-description**	**frequency**
quality of care/treatment	no pressure sore precautions taken by facility	1
quality of care/treatment	resident medications improperly administered	1
quality of care/treatment	resident not assessed after change in condition timely	1
quality of care/treatment	resident safety/falls	1
total substantiated allegations for this facility		**4**

how to read this table:

This table shows the number of HACs that occurred at Spring Valley Hospital Medical Center, including a title and frequency for each condition as well as its CMS condition number.

HOSPITAL-ACQUIRED CONDITIONS (January 1, 2009 – December 31, 2009)	28 total HACs	
condition	**frequency**	**condition number**
foreign object retained after surgery	0	1
air embolism	0	2
blood incompatibility	0	3
stage III and IV pressure ulcers	2	4
falls and trauma	5	5
manifestations of poor glycemic control	0	6
catheter-associated urinary tract infection	1	7
vascular catheter-associated infection	12	8
surgical site infection following coronary artery bypass graft – mediastinitis	0	9A
surgical site infection following bariatric surgery	0	9B
surgical site infection following orthopedic procedures	2	9C
deep vein thrombosis/pulmonary embolism	6	10
total conditions for this facility	**28**	

Spring Valley Hospital Medical Center's Response to the 2009 Annual Hospitals Report

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

Based on the 2009 Nevada Hospital Report finding for hospitals and your organization, **identify priority areas** (i.e., healthcare acquired infections) for short-term and long-term improvement for your organization:

- Short Term Priorities:
  - Reduction in central line (CLABSI) and urinary tract infections (CAUTI)
  - Reduction in falls with serious injury
  - Reduction in hospital-acquired stage III & IV pressure ulcers
- Long Term Priorities:
  - Reduction in overall hospital-acquired infections (HAIs)
  - Reduction in overall hospital-acquired conditions (HACs)
  - Expansion of Deep Vein Thrombosis/Pulmonary Embolism (DVT/PE) protocols
  - Expansion of patient and community involvement in overall patient safety initiatives
  - Continued compliance with National Patient Safety Goals (NPSG)

2A: What is the short-term improvement plan (next 12 months)?

- Participate in the CUSP – BSI national initiative
- Establish protocols and practice to reduce overall use of urinary catheter device and early removal
- Implement all fall reduction strategies outlined by Institute for Healthcare Improvement and in Universal Health Services toolkit
- Implement best practices outlined in HealthInsight (Centers for Medicare and Medicaid 9th Scope of Work) initiative on pressure ulcers

2B: How will the organization measure success?

- Monitor and report all CLABSI to meet CDC benchmarks
- Improve Surgical Care Improvement Process (SCIP) measure compliance regarding urinary device removal
- Reduce falls with serious injury to under the national benchmark for acute care hospitals
- Reduce number of pressure ulcer incidents

3A: What is the long-term improvement plan (next 2-4 years)?

- Continue to identify compliance/opportunities to reduce HAIs and HACs
- Continue monitoring compliance of DVT/PE prophylactics (prevention) protocols
- Increase patient and community involvement in overall patient safety initiatives
- Continue complying with National Patient Safety Goals (NPSG)

3B: How will the organization measure success?

- Compare reduction of HAIs and HACs over previous years
- Compare reduction of DVTs/PEs over previous years
- Utilize social media tools to inform and engage community on patient safety
- Maintain accreditations and licenses

4: Please give a statement of commitment:

The Valley Health System, of which Spring Valley Hospital Medical Center is a part, is committed to providing safe, effective health care for all patients through a mix of hardwired processes, ongoing patient, staff and physician education and improved technology.

St. Rose Dominican Hospitals – Rose de Lima Campus

address:
102 E Lake Mead Pkwy
Henderson NV 89015

phone number:
702-616-5000

website:
www.strosehospitals.org/medical_services/our_hospitals/185510

accreditation:
The Joint Commission

bed count:
145

date of last inspection:
November 3, 2009

categories of services provided:

medical | surgical | obstetrical | acute, non-critical access

services provided:

- anesthesia
- blood bank
- cardiac catheterization laboratory
- cardiac – thoracic surgery
- chemotherapy service
- CT scanner
- dietetic service
- emergency department (dedicated)
- emergency services
- extracorporeal shock wave
- home health services
- ICU – cardiac (non-surgical)
- ICU – medical/surgical
- ICU – surgical
- laboratory – clinical
- magnetic resonance imaging
- neonatal nursery
- nuclear medicine services
- obstetric service
- occupational therapy service
- operating rooms
- opthalmic surgery
- organ bank
- organ transplant services
- orthopedic surgery
- outpatient services
- pediatric services
- pharmacy
- physical therapy services
- post-operative recovery rooms
- radiology services – diagnostic
- respiratory care services
- rehab – inpatient (non-CARF)
- rehab – outpatient
- renal dialysis (acute inpatient)
- social services
- speech pathology services
- surgical services – inpatient
- surgical services – outpatient

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at St. Rose Dominican Hospitals – Rose de Lima Campus, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	2 total inspections	
deficiency	**frequency**	**regulation**
assessment of patient	1	NAC 449.3624
total deficiencies for this facility	**1**	

how to read this table:

This table shows the number of complaints received against St. Rose Dominican Hospitals – Rose de Lima Campus, including state or federal regulation status and whether they were substantiated.

COMPLAINTS (January 1, 2009 – December 31, 2009)	4 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	1	3	0
federal	0	0	0
total complaints for this facility	**1**	**3**	**0**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against St. Rose Dominican Hospitals – Rose de Lima Campus, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	1 substantiated allegation	
allegation category	**sub-description**	**frequency**
resident/patient/client rights	other	1
total substantiated allegations for this facility		**1**

how to read this table:

This table shows the number of HACs that occurred at St. Rose Dominican Hospitals – Rose de Lima Campus, including a title and frequency for each condition as well as its CMS condition number.

HOSPITAL-ACQUIRED CONDITIONS (January 1, 2009 – December 31, 2009)	24 total HACs	
condition	**frequency**	**condition number**
foreign object retained after surgery	0	1
air embolism	0	2
blood incompatibility	0	3
stage III and IV pressure ulcers	0	4
falls and trauma	2	5
manifestations of poor glycemic control	0	6
catheter-associated urinary tract infection	2	7
vascular catheter-associated infection	19	8
surgical site infection following coronary artery bypass graft – mediastinitis	0	9A
surgical site infection following bariatric surgery	1	9B
surgical site infection following orthopedic procedures	0	9C
deep vein thrombosis/pulmonary embolism	0	10
total conditions for this facility	**24**	

St. Rose Dominican Hospitals – Rose de Lima Campus's Response to the 2009 Annual Hospitals Report

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

Each year St. Rose Dominican Hospitals and Catholic Healthcare West (CHW) – our corporate parent, identify quality improvement priorities and establish numerical targets for these priorities to advance the mission and strategic goals for our organization. Prioritization of performance improvement activities are based upon the following criteria:

1. Patient safety
2. Community needs
3. Needs and expectations of patients and families
4. High risk and problem prone occurrences
5. Financial impact
6. Competency of staff and training needs
7. Support of Strategic Plan and Core Measure Initiative

Along with the above, external factors, such as regulatory requirements, public reporting initiatives and healthcare reform are considered and input from a broad range of stake-holder groups (physicians, nurses, and other hospital leaders) is reviewed in the development of these goals.

2A: What is the short-term improvement plan (next 12 months)?

St. Rose Dominican Hospitals – Rose de Lima Campus separates performance improvement activities into 4 categories: Safety, Quality, Patient-Centered Care, and Clinical Efficiency.

Safety	Quality	Patient-Centered Care	Clinical Efficiency
• Reduction of Hospital-acquired pressure ulcers • Sponge Accounting • High Risk Medications • Surgical Checklist • Worker Safety	27 Evidence-Based Process Measures for Selected Conditions: • Pneumonia • Congestive Heart Failure • Acute Myocardial Infarction • Surgical Care Improvement Program	• Communication about medication and discharge instructions • Patient Advisory Groups • Palliative Care • Emergency Department recommendation	• Transformational Care Savings • Medicare Cost per Case Reduction • Denials Reduction • Clinical Documentation Improvement

2B: How will the organization measure success?

St. Rose Dominican Hospitals – Rose de Lima Campus and CHW has developed measurements for all clinical goals and major initiatives. The measurements have clear definitions, databases, performance targets and measurement intervals. Increasingly, performance targets are tied to national benchmarks. SRDH measures and regularly provides results using

standardized reports. These reports present comparisons to performance goals, aggregate CHW results, and where available, national benchmarks. Performance Improvement results are widely distributed and available on line on our SRDH internet site: www.strosehospitals.org/index.htm.

3A: What is the long-term improvement plan (next 2-4 years)?

Safety	Quality	Patient-Centered Care	Clinical Efficiency
National Patient Safety Goals identified by The Joint Commission: • Improve accuracy of patient identification • Improve communication among caregivers • Improve safety using medications • Reduce risk of healthcare-associated infections • Completely reconcile medications across the continuum • Reduce risk of harm resulting from falls • Reduce risk of suicide • Prevent wrong site, wrong procedure, and wrong person surgery	• Top Quartile Quality • Mortality and Complication Reduction • Regulatory Readiness • Quality leadership development • Home Health Quality Improvement • Ambulatory Care	• Patient Advisory Groups • Patient & Family Rights	Readmission Rate for Selected Conditions: • Acute Myocardial Infarction • Congestive Heart Failure • Pneumonia

3B: How will the organization measure success?

Please refer to SECTION 2b.

4: Please give a statement of commitment:

St Rose Dominican Hospitals' integrated health system will provide a continuum of care, with an emphasis on quality, compassionate, and cost effective care. The continuum includes ambulatory services, inpatient services, outpatient services, acute rehab services, home health, health education and wellness. In addition, St. Rose Dominican Hospitals will collaborate with other local area health care providers, social services and community agencies, with a goal to improve the health status of the community and fulfill our commitment to our strategic goals of:

- "Our Patients" The Science of Care Management and Patient Service
- "Our People" Worklife Quality and Workforce Development
- "Our Future" Economic Success and Community Investment

St. Rose Dominican Hospitals – San Martin Campus

address:
8280 W Warm Springs Rd
Las Vegas NV 89113

phone number:
702-492-8509

website:
www.strosehospitals.org/medical_services/our_hospitals/185511

accreditation:
The Joint Commission

bed count:
147

date of last inspection:
September 22, 2009

categories of services provided:


medical


surgical


obstetrical


acute, non-critical access

services provided:

- blood bank
- cardiac catheterization laboratory
- cardiac – thoracic surgery
- chemotherapy service
- CT scanner
- dietetic service
- emergency services
- ICU – cardiac (non-surgical)
- ICU – medical/surgical
- ICU – neonatal
- ICU – surgical
- laboratory – anatomical
- laboratory – clinical
- magnetic resonance imaging
- neonatal nursery
- neurosurgical services
- nuclear medicine services
- obstetric service
- occupational therapy service
- operating rooms
- orthopedic surgery
- outpatient services
- pharmacy
- physical therapy services
- psychiatric services – emergency
- radiology services – diagnostic
- radiology services – therapeutic
- respiratory care services
- rehab – inpatient (non-CARF)
- rehab – outpatient
- renal dialysis (acute inpatient)
- social services
- speech pathology services
- surgical services – inpatient
- surgical services – outpatient

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at St. Rose Dominican Hospitals – San Martin Campus, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	4 total inspections	
deficiency	**frequency**	**regulation**
patient rights: care in safe setting	1	482.13(c)(2)
total deficiencies for this facility	**1**	

how to read this table:

This table shows the number of complaints received against St. Rose Dominican Hospitals – San Martin Campus, including state or federal regulation status and whether they were substantiated.

COMPLAINTS (January 1, 2009 – December 31, 2009)	8 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	0	7	0
federal	0	1	0
total complaints for this facility	**0**	**8**	**0**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against St. Rose Dominican Hospitals – San Martin Campus, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	0 substantiated allegations	
allegation category	**sub-description**	**frequency**
total substantiated allegations for this facility		**0**

how to read this table:

This table shows the number of HACs that occurred at St. Rose Dominican Hospitals – San Martin Campus, including a title and frequency for each condition as well as its CMS condition number.

HOSPITAL-ACQUIRED CONDITIONS (January 1, 2009 – December 31, 2009)	34 total HACs	
condition	**frequency**	**condition number**
foreign object retained after surgery	0	1
air embolism	0	2
blood incompatibility	0	3
stage III and IV pressure ulcers	2	4
falls and trauma	4	5
manifestations of poor glycemic control	0	6
catheter-associated urinary tract infection	3	7
vascular catheter-associated infection	19	8
surgical site infection following coronary artery bypass graft – mediastinitis	0	9A
surgical site infection following bariatric surgery	0	9B
surgical site infection following orthopedic procedures	1	9C
deep vein thrombosis/pulmonary embolism	5	10
total conditions for this facility	**34**	

St. Rose Dominican Hospitals – San Martin Campus's Response to the 2009 Annual Hospitals Report

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

Each year St. Rose Dominican Hospitals and Catholic Healthcare West (CHW) – our corporate parent, identify quality improvement priorities and establish numerical targets for these priorities to advance the mission and strategic goals for our organization. Prioritization of performance improvement activities are based upon the following criteria:

1. Patient safety
2. Community needs
3. Needs and expectations of patients and families
4. High Risk and problem prone occurrences
5. Financial impact
6. Competency of staff and training needs
7. Support of Strategic Plan and Core Measure Initiative

Along with the above, external factors, such as regulatory requirements, public reporting initiatives and healthcare reform are considered and input from a broad range of stake-holder groups (physicians, nurses, and other hospital leaders) is reviewed in the development of these goals.

2A: What is the short-term improvement plan (next 12 months)?

St. Rose Dominican Hospitals – San Martin Campus separates performance improvement activities into 4 categories: Safety, Quality, Patient-Centered Care, and Clinical Efficiency.

Safety	Quality	Patient-Centered Care	Clinical Efficiency
• Reduction of Hospital-acquired pressure ulcers • Sponge Accounting • Perinatal Bundles • High Risk Medications • Surgical Checklist • Worker Safety	27 Evidence-Based Process Measures for Selected Conditions: • Pneumonia • Congestive Heart Failure • Acute Myocardial Infarction • Surgical Care Improvement Program	• Communication about medication and discharge instructions • Patient Advisory Groups • Palliative Care • Emergency Department recommendation	• Transformational Care Savings • Medicare Cost per Case Reduction • Denials Reduction • Clinical Documentation Improvement

2B: How will the organization measure success?

St. Rose Dominican Hospitals – San Martin Campus and CHW has developed measurements for all clinical goals and major initiatives. The measurements have clear definitions, databases, performance targets and measurement intervals. Increasingly, performance targets are tied to national benchmarks. SRDH measures and regularly provides results using

standardized reports. These reports present comparisons to performance goals, aggregate CHW results, and where available, national benchmarks. Performance Improvement results are widely distributed and available on line on our SRDH internet site: http://www.strosehospitals.org/index.htm.

3A: What is the long-term improvement plan (next 2-4 years)?

Safety	Quality	Patient-Centered Care	Clinical Efficiency
National Patient Safety Goals identified by The Joint Commission: • Improve accuracy of patient identification • Improve communication among caregivers • Improve safety using medications • Reduce risk of healthcare-associated infections • Completely reconcile medications across the continuum • Reduce risk of harm resulting from falls • Reduce risk of suicide • Prevent wrong site, wrong procedure, and wrong person surgery	• Top Quartile Quality • Mortality and Complication Reduction • Regulatory Readiness • Quality leadership development • Home Health Quality Improvement • Ambulatory Care	• Patient Advisory Groups • Patient & Family Rights	Readmission Rate for Selected Conditions: • Acute Myocardial Infarction • Congestive Heart Failure • Pneumonia

3B: How will the organization measure success?

Please refer to SECTION 2b.

4: Please give a statement of commitment:

St Rose Dominican Hospitals' integrated health system will provide a continuum of care, with an emphasis on quality, compassionate, and cost effective care. The continuum includes ambulatory services, inpatient services, outpatient services, acute rehab services, home health, health education and wellness. In addition, St. Rose Dominican Hospitals will collaborate with other local area health care providers, social services and community agencies, with a goal to improve the health status of the community and fulfill our commitment to our strategic goals of:

- "Our Patients" The Science of Care Management and Patient Service
- "Our People" Worklife Quality and Workforce Development
- "Our Future" Economic Success and Community Investment

St. Rose Dominican Hospitals – Siena Campus

address:
3001 Saint Rose Pkwy
Henderson NV 89052

phone number:
702-616-5000

website:
www.strosehospitals.org/medical_services/our_hospitals/185512

accreditation:
The Joint Commission

bed count:
219

date of last inspection:
December 1, 2009

categories of services provided:

medical | surgical | obstetrical | acute, non-critical access

services provided:

- anesthesia
- blood bank
- cardiac catheterization laboratory
- cardiac – thoracic surgery
- chemotherapy service
- CT scanner
- dietetic service
- emergency department (dedicated)
- emergency services
- extracorporeal shock wave
- ICU – cardiac (non-surgical)
- ICU – medical/surgical
- ICU – neonatal
- ICU – pediatric
- ICU – surgical
- laboratory – clinical
- magnetic resonance imaging
- neonatal nursery
- neurosurgical services
- nuclear medicine services
- obstetric service
- occupational therapy service
- operating rooms
- opthalmic surgery
- organ bank
- organ transplant services
- orthopedic surgery
- outpatient services
- pediatric services
- pharmacy
- physical therapy services
- positron emission tomography
- post-operative recovery rooms
- radiology services – diagnostic
- radiology services – therapeutic
- reconstructive services
- respiratory care services
- rehab – inpatient (non-CARF)
- rehab – outpatient
- renal dialysis (acute inpatient)
- social services
- speech pathology services
- surgical services – inpatient
- surgical services – outpatient
- trauma center (certified)

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at St. Rose Dominican Hospitals – Siena Campus, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	10 total inspections	
deficiency	**frequency**	**regulation**
adequate respiratory care staffing	1	482.57(a)(2)
administration of drugs	1	482.23(c)
blood gases/lab test requirements	1	482.57(b)(2)
construction standards	1	NAC 449.3154
content of record – informed consent	1	482.24(c)(2)(v)
director of dietary services	1	482.28(a)(1)
discharge planning	1	NAC 449.332
emergency services	2	482.55
life safety code standard	2	NFPA 101
patient rights: care in safe setting	2	482.13(c)(2)
potentially infectious blood/blood products	1	482.27(b)
qualified emergency services personnel	1	482.55(b)(2)
qualified staff	1	482.26(c)(2)
use of restraint or seclusion	1	482.13(e)
total deficiencies for this facility	**17**	

how to read this table:

This table shows the number of complaints received against St. Rose Dominican Hospitals – Siena Campus, including state or federal regulation status and whether they were substantiated.

COMPLAINTS (January 1, 2009 – December 31, 2009)	8 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	2	4	0
federal	1	1	0
total complaints for this facility	**3**	**5**	**0**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against St. Rose Dominican Hospitals – Siena Campus, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	3 substantiated allegations	
allegation category	**sub-description**	**frequency**
admission, transfer and discharge rights		1
resident/patient/client neglect		1
resident/patient/client rights		1
total substantiated allegations for this facility		**3**

how to read this table:

This table shows the number of HACs that occurred at St. Rose Dominican Hospitals – Siena Campus, including a title and frequency for each condition as well as its CMS condition number.

HOSPITAL-ACQUIRED CONDITIONS (January 1, 2009 – December 31, 2009)	78 total HACs	
condition	**frequency**	**condition number**
foreign object retained after surgery	0	1
air embolism	0	2
blood incompatibility	0	3
stage III and IV pressure ulcers	4	4
falls and trauma	6	5
manifestations of poor glycemic control	0	6
catheter-associated urinary tract infection	3	7
vascular catheter-associated infection	56	8
surgical site infection following coronary artery bypass graft – mediastinitis	0	9A
surgical site infection following bariatric surgery	0	9B
surgical site infection following orthopedic procedures	0	9C
deep vein thrombosis/pulmonary embolism	9	10
total conditions for this facility	**78**	

St. Rose Dominican Hospitals – Siena Campus's Response to the 2009 Annual Hospitals Report

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

Each year St. Rose Dominican Hospitals and Catholic Healthcare West (CHW) – our corporate parent, identify quality improvement priorities and establish numerical targets for these priorities to advance the mission and strategic goals for our organization. Prioritization of performance improvement activities are based upon the following criteria:

1. Patient safety
2. Community needs
3. Needs and expectations of patients and families
4. High Risk and problem prone occurrences
5. Financial impact
6. Competency of staff and training needs
7. Support of Strategic Plan and Core Measure Initiative

Along with the above, external factors, such as regulatory requirements, public reporting initiatives and healthcare reform are considered and input from a broad range of stake-holder groups (physicians, nurses, and other hospital leaders) is reviewed in the development of these goals.

2A: What is the short-term improvement plan (next 12 months)?

St. Rose Dominican Hospitals – Siena Campus separates performance improvement activities into 4 categories: Safety, Quality, Patient-Centered Care, and Clinical Efficiency.

Safety	Quality	Patient-Centered Care	Clinical Efficiency
• Reduction of Hospital-acquired pressure ulcers • Sponge Accounting • Perinatal Bundles • High Risk Medications • Surgical Checklist • Worker Safety	27 Evidence-Based Process Measures for Selected Conditions: • Pneumonia • Congestive Heart Failure • Acute Myocardial Infarction • Surgical Care Improvement Program	• Communication about medication and discharge instructions • Patient Advisory Groups • Palliative Care • Emergency Department recommendation	• Transformational Care Savings • Medicare Cost per Case Reduction • Denials Reduction • Clinical Documentation Improvement

2B: How will the organization measure success?

St. Rose Dominican Hospitals – Siena Campus and CHW has developed measurements for all clinical goals and major initiatives. The measurements have clear definitions, databases, performance targets and measurement intervals. Increasingly, performance targets are tied to national benchmarks. SRDH measures and regularly provides results using

standardized reports. These reports present comparisons to performance goals, aggregate CHW results, and where available, national benchmarks. Performance Improvement results are widely distributed and available on line on our SRDH internet site: http://www.strosehospitals.org/index.htm.

3A: What is the long-term improvement plan (next 2-4 years)?

Safety	Quality	Patient-Centered Care	Clinical Efficiency
National Patient Safety Goals identified by The Joint Commission: • Improve accuracy of patient identification • Improve communication among caregivers • Improve safety using medications • Reduce risk of healthcare-associated infections • Completely reconcile medications across the continuum • Reduce risk of harm resulting from falls • Reduce risk of suicide • Prevent wrong site, wrong procedure, and wrong person surgery	• Top Quartile Quality • Mortality and Complication Reduction • Regulatory Readiness • Quality leadership development • Home Health Quality Improvement • Ambulatory Care	• Patient Advisory Groups • Patient & Family Rights	Readmission Rate for Selected Conditions: • Acute Myocardial Infarction • Congestive Heart Failure • Pneumonia

3B: How will the organization measure success?

Please refer to SECTION 2b.

4: Please give a statement of commitment:

St Rose Dominican Hospitals' integrated health system will provide a continuum of care, with an emphasis on quality, compassionate, and cost effective care. The continuum includes ambulatory services, inpatient services, outpatient services, acute rehab services, home health, health education and wellness. In addition, St. Rose Dominican Hospitals will collaborate with other local area health care providers, social services and community agencies, with a goal to improve the health status of the community and fulfill our commitment to our strategic goals of:

- "Our Patients" The Science of Care Management and Patient Service
- "Our People" Worklife Quality and Workforce Development
- "Our Future" Economic Success and Community Investment

Summerlin Hospital Medical Center

address:
657 N Town Center Dr
Las Vegas NV 89144

phone number:
702-233-7000

website:
www.summerlinhospital.com

accreditation:
The Joint Commission

average annual bed count:
295

date of last inspection:
November 3, 2009

categories of services provided:


medical


surgical


obstetrical


acute, non-critical access

services provided:

- anesthesia
- cardiac catheterization laboratory
- cardiac – thoracic surgery
- chemotherapy service
- CT scanner
- dental service
- dietetic service
- emergency department (dedicated)
- emergency services
- home health services
- ICU – cardiac (non-surgical)
- ICU – medical/surgical
- ICU – neonatal
- ICU – pediatric
- ICU – surgical
- laboratory – clinical
- magnetic resonance imaging
- long term care (swing-beds)
- neonatal nursery
- nuclear medicine services
- obstetric service
- occupational therapy service
- operating rooms
- opthalmic surgery
- orthopedic surgery
- outpatient services
- pediatric services
- pharmacy
- physical therapy services
- post-operative recovery rooms
- psychiatric services – emergency
- radiology services – diagnostic
- radiology services – therapeutic
- respiratory care services
- rehab – inpatient (non-CARF)
- rehab – outpatient
- renal dialysis (acute inpatient)
- social services
- speech pathology services
- surgical services – inpatient
- surgical services – outpatient

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Summerlin Hospital Medical Center, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	9 total inspections	
deficiency	**frequency**	**regulation**
appropriate care of patient	1	NAC 449.3622
discharge planning	2	NAC 449.332
medical records	1	NAC 449.379
personnel policies	1	NAC 449.363
sterile supplies and medical equipment	1	NAC 449.327
total deficiencies for this facility	**6**	

how to read this table:

This table shows the number of complaints received against Summerlin Hospital Medical Center, including state or federal regulation status and whether they were substantiated. The 1 other complaint was referred to another agency.

COMPLAINTS (January 1, 2009 – December 31, 2009)	8 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	2	5	1
federal	0	0	0
total complaints for this facility	**2**	**2**	**1**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Summerlin Hospital Medical Center, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	2 substantiated allegations	
allegation category	**sub-description**	**frequency**
quality of care/treatment		2
total substantiated allegations for this facility		**2**

how to read this table:

This table shows the number of HACs that occurred at Summerlin Hospital Medical Center, including a title and frequency for each condition as well as its CMS condition number.

HOSPITAL-ACQUIRED CONDITIONS (January 1, 2009 – December 31, 2009)	17 total HACs	
condition	**frequency**	**condition number**
foreign object retained after surgery	1	1
air embolism	0	2
blood incompatibility	0	3
stage III and IV pressure ulcers	0	4
falls and trauma	2	5
manifestations of poor glycemic control	0	6
catheter-associated urinary tract infection	5	7
vascular catheter-associated infection	6	8
surgical site infection following coronary artery bypass graft – mediastinitis	0	9A
surgical site infection following bariatric surgery	0	9B
surgical site infection following orthopedic procedures	0	9C
deep vein thrombosis/pulmonary embolism	3	10
total conditions for this facility	**17**	

Summerlin Hospital Medical Center's Response to the 2009 Annual Hospitals Report

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

Based on the 2009 Nevada Hospital Report finding for hospitals and your organization, **identify priority areas** (i.e., healthcare acquired infections) for short-term and long-term improvement for your organization:

- Short Term Priorities:
  - Reduction in central line (CLABSI) and urinary tract infections (CAUTI)
  - Reduction in falls with serious injury
  - Reduction in hospital-acquired stage III & IV pressure ulcers
- Long Term Priorities:
  - Reduction in overall hospital-acquired infections (HAIs)
  - Reduction in overall hospital-acquired conditions (HACs)
  - Expansion of Deep Vein Thrombosis/Pulmonary Embolism (DVT/PE) protocols
  - Expansion of patient and community involvement in overall patient safety initiatives
  - Continued compliance with National Patient Safety Goals (NPSG)

2A: What is the short-term improvement plan (next 12 months)?

- Participate in the CUSP – BSI national initiative
- Establish protocols and practice to reduce overall use of urinary catheter device and early removal
- Implement all fall reduction strategies outlined by Institute for Healthcare Improvement and in Universal Health Services toolkit
- Implement best practices outlined in HealthInsight (Centers for Medicare and Medicaid 9th Scope of Work) initiative on pressure ulcers

2B: How will the organization measure success?

- Monitor and report all CLABSI to meet CDC benchmarks
- Improve Surgical Care Improvement Process (SCIP) measure compliance regarding urinary device removal
- Reduce falls with serious injury to under the national benchmark for acute care hospitals
- Reduce number of pressure ulcer incidents

3A: What is the long-term improvement plan (next 2-4 years)?

- Continue to identify compliance/opportunities to reduce HAIs and HACs
- Continue monitoring compliance of DVT/PE prophylactics (prevention) protocols
- Increase patient and community involvement in overall patient safety initiatives
- Continue complying with National Patient Safety Goals (NPSG)

3B: How will the organization measure success?

- Compare reduction of HAIs and HACs over previous years
- Compare reduction of DVTs/PEs over previous years
- Utilize social media tools to inform and engage community on patient safety
- Maintain accreditations and licenses

4: Please give a statement of commitment:

The Valley Health System, of which Summerlin Hospital Medical Center is a part, is committed to providing safe, effective health care for all patients through a mix of hardwired processes, ongoing patient, staff and physician education and improved technology.

Sunrise Hospital and Medical Center

address:
3186 S Maryland Pkwy
Las Vegas NV 89109

phone number:
702-731-8000

website:
www.sunrisehospital.com

accreditation:
The Joint Commission

bed count:
701

date of last inspection:
December 8, 2009

categories of services provided:


medical


surgical


obstetrical


acute, non-critical access

services provided:

- anesthesia
- blood bank
- cardiac catheterization laboratory
- cardiac – thoracic surgery
- chemotherapy service
- CT scanner
- dietetic service
- emergency department (dedicated)
- emergency services
- ICU – cardiac (non-surgical)
- ICU – medical/surgical
- ICU – neonatal
- ICU – pediatric
- ICU – surgical
- laboratory – anatomical
- laboratory – clinical
- magnetic resonance imaging
- neonatal nursery
- neurosurgical services
- nuclear medicine services
- obstetric service
- occupational therapy service
- operating rooms
- opthalmic surgery
- orthopedic surgery
- outpatient services
- pediatric services
- pharmacy
- physical therapy services
- positron emission tomography
- post-operative recovery rooms
- radiology services – diagnostic
- radiology services – therapeutic
- reconstructive services
- respiratory care services
- rehab – inpatient (CARF acc)
- renal dialysis (acute inpatient)
- social services
- speech pathology services
- surgical services – inpatient
- surgical services – outpatient
- trauma center (certified)

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Sunrise Hospital and Medical Center, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	8 total inspections	
deficiency	**frequency**	**regulation**
appropriate care of patient	2	NAC 449.3622
assessment of patient	1	NAC 449.3624
nursing service	1	NAC 449.361
total deficiencies for this facility	**4**	

how to read this table:

This table shows the number of complaints received against Sunrise Hospital and Medical Center, including state or federal regulation status and whether they were substantiated. Of the 4 other complaints, 3 were referred, and 1 is under administrative/off-site investigation.

COMPLAINTS (January 1, 2009 – December 31, 2009)	17 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	5	8	4
federal	0	0	0
total complaints for this facility	**5**	**8**	**4**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Sunrise Hospital and Medical Center, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	8 substantiated allegations	
allegation category	**sub-description**	**frequency**
infection control		1
quality of care/treatment		1
quality of care/treatment	care/service not received per physician's order	2
quality of care/treatment	resident medications not given according to physician instructions	2
quality of care/treatment	resident not assessed after change in condition timely	2
total substantiated allegations for this facility		**8**

how to read this table:

This table shows the number of HACs that occurred at Sunrise Hospital and Medical Center, including a title and frequency for each condition as well as its CMS condition number.

HOSPITAL-ACQUIRED CONDITIONS (January 1, 2009 – December 31, 2009)	80 total HACs	
condition	**frequency**	**condition number**
foreign object retained after surgery	5	1
air embolism	0	2
blood incompatibility	0	3
stage III and IV pressure ulcers	28	4
falls and trauma	8	5
manifestations of poor glycemic control	2	6
catheter-associated urinary tract infection	2	7
vascular catheter-associated infection	34	8
surgical site infection following coronary artery bypass graft – mediastinitis	0	9A
surgical site infection following bariatric surgery	0	9B
surgical site infection following orthopedic procedures	0	9C
deep vein thrombosis/pulmonary embolism	1	10
total conditions for this facility	**80**	

Sunrise Hospital and Medical Center's Response to the 2009 Annual Hospitals Report

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

Top three priorities consist of eliminating healthcare associated-infections (HAI), reducing hospital acquired-conditions (HAC) and implementing an electronic health record.

2A: What is the short-term improvement plan (next 12 months)?

Sunrise Hospital is participating in the Comprehensive Unit-based Safety Program (CUSP) model, which was developed by the Johns Hopkins Quality and Safety Research Group. This model was first used in the Keystone Project, along with CLABSI elimination protocols, and is estimated to have saved 1,200 lives per year and reduced costs by $175 million annually. The CUSP model is now a national collaborative funded by AHRQ. As an adjunct to CUSP, Sunrise Hospital has launched an internal initiative called Aim for Zero Campaign. This campaign expands on the insertion bundle that Dr. Peter Pronovost developed in the Keystone Project and adds a second unique bundle focusing on maintenance of central lines. The goal of these projects is to eliminate CLABSIs.

AHRQ and the Defense Department have teamed to build a national training and support network called the National Implementation of TeamSTEPPS Project. Sunrise Hospital has begun a TeamSTEPPS journey in its surgical services area. TeamSTEPPS is a teamwork system designed for health care professionals that is a powerful solution to improve patient safety within an organization and an evidence-based teamwork system to improve communication and teamwork skills among health care professionals.

2B: How will the organization measure success?

HAI, HAC, Sentinel Events and HCAHPS data will all indicate if improvement is achieved.

3A: What is the long-term improvement plan (next 2-4 years)?

By 2015, Sunrise Hospital will implement a fully integrated Electronic Health Record (EHR). An EHR is a secure, real-time, point-of-care, patient-centric information resource for clinicians. The EHR aids clinicians' decision-making by providing access to patient health record information where and when they need it and by incorporating evidence-based decision support. The EHR automates and streamlines the clinician's workflow, closing loops in communication and response that result in delays or gaps in care. The EHR also supports the collection of data for uses other than direct clinical care, such as billing, quality management, outcomes reporting, resource planning, and public health disease surveillance and reporting (HIMSS). It is our belief that the EHR will be one of the most fundamental support systems for optimizing the safety, quality, effectiveness and efficiency of healthcare that we provide.

3B: How will the organization measure success?

By accomplishing Stages I, II and III of Meaningful Use set by the HITECH Act.

4: Please give a statement of commitment:

Our initiatives harmonize with the best practice recommendations set forth by the NQF's Safe Practices and The Joint Commission's standards. We collaborate with local and national patient safety organizations, including NHA Patient Safety Committee; the Southern Nevada Health District; HealthInsight; the Institute for Safe Medication Practices; the Institute for Healthcare Improvement; the Leapfrog Group; and the National Patient Safety Foundation, all in an effort to ensure a safe environment and experience for our patients, staff and physicians.

Tahoe Pacific Hospitals – Meadows

address:
10101 Double R Blvd
Reno NV 89521

phone number:
775-331-1044

website:
www.lifecare-hospitals.com/hospital.php?id=13

accreditation:
The Joint Commission

bed count:
39

date of last inspection:
September 14, 2009

categories of services provided:


medical


surgical

services provided:

- CT scanner
- laboratory – clinical
- magnetic resonance imaging
- occupational therapy service
- pharmacy
- physical therapy services
- radiology services – diagnostic
- radiology services – therapeutic
- respiratory care services
- rehab – inpatient (non-CARF)
- renal dialysis (acute inpatient)
- social services
- speech pathology services

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Tahoe Pacific Hospitals – Meadows, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	1 total inspection	
deficiency	**frequency**	**regulation**
total deficiencies for this facility	**0**	

how to read this table:

This table shows the number of complaints received against Tahoe Pacific Hospitals – Meadows, including state or federal regulation status and whether they were substantiated.

COMPLAINTS (January 1, 2009 – December 31, 2009)	1 total complaint		
complaint	**substantiated**	**unsubstantiated**	**other**
state	0	1	0
federal	0	0	0
total complaints for this facility	**0**	**1**	**0**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Tahoe Pacific Hospitals – Meadows, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	0 substantiated allegations	
allegation category	**sub-description**	**frequency**
total substantiated allegations for this facility		**0**

Tahoe Pacific Hospitals – Meadows' Response to the 2009 Annual Hospitals Report

We are working to provide for our patients a safe, quality driven environment base on established national guidelines.

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

Tahoe Pacific Hospitals will focus on 4 priority areas: 1.) the prevention of hospital-acquired central Line infections, 2.) the prevention of hospital-acquired ventilator associated pneumonia, 3.) the prevention of hospital-acquired Foley catheter related urinary tract infections, and 4.) the prevention of patient falls.

2A: What is the short-term improvement plan (next 12 months)?

The Hospital will continue the use of evidence-based clinical bundles, proven to reduce infections. These are already in use, but refinement and attention to strict adherence will be implemented. We will also work on the reduction of central line and Foley catheter use. Our falls committee will continue its work on fall risk assessment and fall reduction strategies including hourly rounding.

2B: How will the organization measure success?

Measurements will be made using CDC guidelines and results compared against corporate measures, CUSP data and data from the ALTHA (Acute Long Term Hospital Association) indicators.

3A: What is the long-term improvement plan (next 2-4 years)?

For the long and also short term, the hospital has joined with many State of Nevada hospitals and the Nevada Hospital Association in embracing the CUSP program. We plan to use the techniques in this program to increase the hospitals safety awareness and safety culture, helping us eliminate these hospital-acquired infections from our facilities. We will implement a multi-faceted approach including implementation of new technologies for environmental cleaning, hand hygiene and antibiotic stewardship.

3B: How will the organization measure success?

We will compare yearly data for reduction trends in our facility and regional and national as described earlier.

4: Please give a statement of commitment:

We are committed to make our facility as safe as possible using the latest technologies and following the latest proven guidelines of patient care.

Tahoe Pacific Hospitals – West

address:
235 W 6th St
Reno NV 89503

phone number:
775-770-7980

website:
www.lifecare-hospitals.com/hospital.php?id=13

accreditation:
The Joint Commission
(under Tahoe Pacific Hospitals – Meadows)

bed count:
21

date of last inspection:
December 28, 2009

categories of services provided:

medical

surgical

services provided:

- CT scanner
- laboratory – clinical
- magnetic resonance imaging
- occupational therapy service
- pharmacy
- physical therapy services
- radiology services – diagnostic
- radiology services – therapeutic
- respiratory care services
- rehab – inpatient (non-CARF)
- renal dialysis (acute inpatient)
- social services
- speech pathology services

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Tahoe Pacific Hospitals – West, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	1 total inspection	
deficiency	**frequency**	**regulation**
personnel policies	1	NAC 449.363
pharmaceutical services	1	NAC 449.340
total deficiencies for this facility	**2**	

how to read this table:

This table shows the number of complaints received against Tahoe Pacific Hospitals – West, including state or federal regulation status and whether they were substantiated.

COMPLAINTS (January 1, 2009 – December 31, 2009)	0 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	0	0	0
federal	0	0	0
total complaints for this facility	**0**	**0**	**0**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Tahoe Pacific Hospitals – West, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	0 substantiated allegations	
allegation category	**sub-description**	**frequency**
total substantiated allegations for this facility		**0**

Tahoe Pacific Hospitals – West's Response to the 2009 Annual Hospitals Report

We are working to provide for our patients a safe, quality driven environment base on established national guidelines.

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

Tahoe Pacific Hospitals will focus on 4 priority areas: 1.) the prevention of hospital-acquired central Line infections, 2.) the prevention of hospital-acquired ventilator associated pneumonia, 3.) the prevention of hospital-acquired foley catheter related urinary tract infections, and 4.) the prevention of patient falls.

2A: What is the short-term improvement plan (next 12 months)?

The Hospital will continue the use of evidence-based clinical bundles, proven to reduce infections. These are already in use, but refinement and attention to strict adherence will be implemented. We will also work on the reduction of central line and Foley catheter use. Our falls committee will continue its work on fall risk assessment and fall reduction strategies including hourly rounding.

2B: How will the organization measure success?

Measurements will be made using CDC guidelines and results compared against corporate measures, CUSP data and data from the ALTHA (Acute Long Term Hospital Association) indicators.

3A: What is the long-term improvement plan (next 2-4 years)?

For the long and also short term, the hospital has joined with many State of Nevada hospitals and the Nevada Hospital Association in embracing the CUSP program. We plan to use the techniques in this program to increase the hospitals safety awareness and safety culture, helping us eliminate these hospital-acquired infections from our facilities. We will implement a multi-faceted approach including implementation of new technologies for environmental cleaning, hand hygiene and antibiotic stewardship.

3B: How will the organization measure success?

We will compare yearly data for reduction trends in our facility and regional and national as described earlier.

4: Please give a statement of commitment:

We are committed to make our facility as safe as possible using the latest technologies and following the latest proven guidelines of patient care.

University Medical Center of Southern Nevada

address:
1800 W Charleston Blvd
Las Vegas NV 89102

phone number:
702-383-2000

website:
home.umcsn.com

accreditation:
The Joint Commission

bed count:
541

date of last inspection:
December 31, 2009

categories of services provided:

medical | surgical | obstetrical | acute, non-critical access

services provided:

- anesthesia
- audiology
- blood bank
- burn care unit
- cardiac catheterization laboratory
- cardiac – thoracic surgery
- chemotherapy service
- CT scanner
- dietetic service
- emergency department (dedicated)
- emergency services
- extracorporeal shock wave
- ICU – cardiac (non-surgical)
- ICU – medical/surgical
- ICU – neonatal
- ICU – pediatric
- ICU – surgical
- laboratory – anatomical
- laboratory – clinical
- magnetic resonance imaging
- neonatal nursery
- neurosurgical services
- nuclear medicine services
- obstetric service
- occupational therapy service
- operating rooms
- opthalmic surgery
- organ transplant services
- orthopedic surgery
- outpatient services
- pediatric services
- pharmacy
- physical therapy services
- post-operative recovery rooms
- radiology services – diagnostic
- reconstructive services
- respiratory care services
- rehab – outpatient
- renal dialysis (acute inpatient)
- social services
- speech pathology services
- surgical services – inpatient
- surgical services – outpatient
- trauma center (certified)
- transplant center, Medicare certified
- urgent care center services

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at University Medical Center of Southern Nevada, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	13 total inspections	
deficiency	**frequency**	**regulation**
administration of drugs	2	482.23(c)
blood transfusions	2	NAC 449.3735
compliance with 489.24	1	489.20(l)
confidentiality of medical records	1	482.24(b)(3)
construction standards	3	NAC 449.3154
dietary services	1	NAC 449.338
emergency services	1	NAC 449.331
governing body	1	482.12
infections and communicable diseases	1	NAC 449.325
medical record services	1	482.24
medical records	3	NAC 449.379
medical screening exam	1	489.24(r) & 489.24(c)
nursing service	1	NAC 449.361
operating budget	1	NAC 449.313
operating room policies	1	482.51(b)
patient rights	1	482.13
patient rights: confidentiality of records	2	482.13(d)
personnel policies	1	NAC 449.363
QAPI	1	482.21
quality improvement program	1	NAC 449.3152
rights of patient	2	NAC 449.3626
sanitary conditions – supplies for food	1	NAC 449.3395
total deficiencies for this facility	**30**	

how to read this table:

This table shows the number of complaints received against University Medical Center of Southern Nevada, including state or federal regulation status and whether they were substantiated. Of the 14 other complaints, no action was necessary for 2, 7 were referred, 3 are under investigation, and 2 are under administrative/off-site investigation.

COMPLAINTS (January 1, 2009 – December 31, 2009)	35 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	4	15	13
federal	0	2	1
total complaints for this facility	**4**	**17**	**14**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against University Medical Center of Southern Nevada, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	8 substantiated allegations	
allegation category	**sub-description**	**frequency**
death – general		1
EMTALA (patient dumping)	screening	1
infection control		1
physical environment	no hot water	1
physician services	other	1
quality of care/treatment		1
quality of care/treatment	no pressure sore precautions taken by facility	1
resident/patient/client neglect	assess/monitor	1
total substantiated allegations for this facility		**8**

how to read this table:

This table shows the number of HACs that occurred at University Medical Center of Southern Nevada, including a title and frequency for each condition as well as its CMS condition number.

HOSPITAL-ACQUIRED CONDITIONS (January 1, 2009 – December 31, 2009)	59 total HACs	
condition	**frequency**	**condition number**
foreign object retained after surgery	5	1
air embolism	0	2
blood incompatibility	0	3
stage III and IV pressure ulcers	10	4
falls and trauma	1	5
manifestations of poor glycemic control	2	6
catheter-associated urinary tract infection	3	7
vascular catheter-associated infection	34	8
surgical site infection following coronary artery bypass graft – mediastinitis	0	9A
surgical site infection following bariatric surgery	1	9B
surgical site infection following orthopedic procedures	3	9C
deep vein thrombosis/pulmonary embolism	0	10
total conditions for this facility	**59**	

University Medical Center of Southern Nevada's Response to the 2009 Annual Hospitals Report

Identify Priority Areas for Your Hospital

UMC is dedicated to the continuous improvement of overall quality of care and patient safety. We have identified two specific focus areas for the purpose of example, to demonstrate UMC's improvement plans and measures for success: throughput to the hospital and infection control.

Throughput from the Emergency Department to Hospital

Moving patients through the UMC Emergency Department more efficiently, with greater focus on continuity of care from UMC Quick Care Clinics.

Short Term Improvement Plan: UMC changed the staffing mix in the Emergency Department to put more emphasis on timely patient assessment. UMC also extended physician coverage for rapid medical assessment to ensure patients are seen by a doctor in a more timely fashion.

Long Term Improvement Plan: UMC has obtained funding to begin redesign of the Emergency Department to better facilitate patient flow.

How will UMC measure success: Under ongoing leadership, UMC will measure the success of improvement plans to hospital throughput by monitoring a dashboard of overall patient wait times that can pinpoint the roadblocks to optimal patient flow.

Infection Control

Continued education, prevention and transparency of all factors concerning infection control, ensuring best practices are made policy and monitoring that the best practices are followed.

Short Term Improvement Plan: UMC is now using the "Institute for Healthcare Improvement" approved central line bundles. These standardized central line kits assist practitioners in meeting infection control guidelines. Additionally, UMC has augmented infection control staff to enhance surveillance of infection control practices.

Long Term Improvement Plan: UMC's Director of Infection Control participates nationally with the Centers for Disease Control and Prevention's National Healthcare Safety Network to benchmark infection control rates against our peers. Additionally, UMC will implement standardized physician orders and provide ongoing education to all practitioners. Further, UMC employs a full time Infection Control Physician available for patient consults and education related to infection control.

How will UMC measure success: UMC will measure the success of infection control procedures through ongoing surveillance of infection control prevention practices. There is 100% review of all patient cultures and observance of the monthly dashboard of infection rates that is constantly reviewed by leadership.

Commitment Statement

UMC is committed to ongoing transparency through self-reporting and education on our website, umcsn.com. In fact, UMC is one of the only hospitals in southern Nevada that has made such a commitment to providing full disclosure of patient quality and safety statistics. UMC encourages our patients and families to partner with us in our continued commitment to transparency and ongoing efforts in improving patient quality and safety, in order to meet our goal of Patient/Family-Centered Care.

University Medical Center Rancho Rehabilitation Center

address:
4333 N Rancho Dr
Las Vegas NV 89130

phone number:
702-656-0470

website:
NA

accreditation:
The Joint Commission
(under University Medical Center of Southern Nevada)

bed count:
34

date of last inspection:
November 3, 2009

date closed:
November 25, 2009

categories of services provided:

medical

services provided:

- rehab – inpatient (CARF acc)

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at University Medical Center Rancho Rehabilitation Center, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	1 total inspection	
deficiency	**frequency**	**regulation**
appropriate care of patient	1	NAC 449.3622
assessment of patient	2	NAC 449.3624
pharmaceutical services	1	NAC 449.340
protection of patients	1	NAC 449.3628
total deficiencies for this facility	**5**	

how to read this table:

This table shows the number of complaints received against University Medical Center Rancho Rehabilitation Center, including state or federal regulation status and whether they were substantiated.

COMPLAINTS (January 1, 2009 – December 31, 2009)	2 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	2	0	0
federal	0	0	0
total complaints for this facility	**2**	**0**	**0**

how to read this table:

This table shows the number of substantiated allegations associated with complaints University Medical Center Rancho Rehabilitation Center, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	3	
allegation category	**sub-description**	**frequency**
misappropriation of property		1
quality of care/treatment	resident safety/falls	1
resident/patient/client assessment		1
total substantiated allegations for this facility		**3**

Valley Hospital Medical Center

address:
620 Shadow Ln
Las Vegas NV 89106

phone number:
702-388-4000

website:
www.valleyhospital.net

accreditation:
The Joint Commission

bed count:
404

date of last inspection:
November 17, 2009

categories of services provided:

medical | surgical | obstetrical | acute, non-critical access

services provided:

- anesthesia
- blood bank
- cardiac catheterization laboratory
- cardiac – thoracic surgery
- CT scanner
- dietetic service
- emergency services
- emergency department (dedicated)
- ICU – medical/surgical
- ICU – neonatal
- ICU – surgical
- laboratory – clinical
- magnetic resonance imaging
- neonatal surgery
- neurosurgical services
- nuclear medicine services
- obstetric service
- occupational therapy service
- operating rooms
- orthopedic surgery
- outpatient services
- pharmacy
- pediatric services
- pharmacy
- physical therapy services
- post-operative recovery rooms
- radiology services – diagnostic
- respiratory care services
- renal dialysis (acute inpatient)
- social services
- speech pathology services
- surgical services – inpatient
- surgical services – outpatient
- urgent care center services

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Valley Hospital Medical Center, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	7 total inspections	
deficiency	**frequency**	**regulation**
assessment of patient	3	NAC 449.3624
compliance with 489.24	1	489.20(l)
governing body	1	NAC 449.313
housekeeping services	2	NAC 449.322
medical screening exam	1	489.24(r) & 489.24(c)
nursing service	1	NAC 449.361
personnel policies	1	NAC 449.363
physical restraint use	3	NAC 449.3628
total deficiencies for this facility	**13**	

how to read this table:

This table shows the number of complaints received against Valley Hospital Medical Center, including state or federal regulation status and whether they were substantiated. Of the 2 other complaints, no action was necessary for 1 and 1 was referred to another agency.

COMPLAINTS (January 1, 2009 – December 31, 2009)	13 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	5	5	2
federal	1	0	0
total complaints for this facility	**6**	**5**	**2**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Valley Hospital Medical Center, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	8 substantiated allegations	
allegation category	**sub-description**	**frequency**
administration/personnel		1
EMTALA (patient dumping)	policies/procedures	1
EMTALA (patient dumping)	screening	1
physical environment	facility not clean	2
quality of care/treatment	no pressure sore precautions taken by facility	1
quality of care/treatment	resident medications improperly administered	1
resident/patient/client neglect	pressure sores	1
total substantiated allegations for this facility		**8**

how to read this table:

This table shows the number of HACs that occurred at Valley Hospital Medical Center, including a title and frequency for each condition as well as its CMS condition number.

HOSPITAL-ACQUIRED CONDITIONS (January 1, 2009 – December 31, 2009)	35 total HACs	
condition	**frequency**	**condition number**
foreign object retained after surgery	2	1
air embolism	0	2
blood incompatibility	0	3
stage III and IV pressure ulcers	4	4
falls and trauma	5	5
manifestations of poor glycemic control	0	6
catheter-associated urinary tract infection	5	7
vascular catheter-associated infection	19	8
surgical site infection following coronary artery bypass graft – mediastinitis	0	9A
surgical site infection following bariatric surgery	0	9B
surgical site infection following orthopedic procedures	0	9C
deep vein thrombosis/pulmonary embolism	0	10
total conditions for this facility	**35**	

Valley Hospital Medical Center's Response to the 2009 Annual Hospitals Report

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

Based on the 2009 Nevada Hospital Report finding for hospitals and your organization, **identify priority areas** (i.e., healthcare acquired infections) for short-term and long-term improvement for your organization:

- Short Term Priorities:
  - Reduction in central line (CLABSI) and urinary tract infections (CAUTI)
  - Reduction in falls with serious injury
  - Reduction in hospital-acquired stage III & IV pressure ulcers
- Long Term Priorities:
  - Reduction in overall hospital-acquired infections (HAIs)
  - Reduction in overall hospital-acquired conditions (HACs)
  - Expansion of Deep Vein Thrombosis/Pulmonary Embolism (DVT/PE) protocols
  - Expansion of patient and community involvement in overall patient safety initiatives
  - Continued compliance with National Patient Safety Goals (NPSG)

2A: What is the short-term improvement plan (next 12 months)?

- Participate in the CUSP – BSI national initiative
- Establish protocols and practice to reduce overall use of urinary catheter device and early removal
- Implement all fall reduction strategies outlined by Institute for Healthcare Improvement and in Universal Health Services toolkit
- Implement best practices outlined in HealthInsight (Centers for Medicare and Medicaid 9th Scope of Work) initiative on pressure ulcers

2B: How will the organization measure success?

- Monitor and report all CLABSI to meet CDC benchmarks
- Improve Surgical Care Improvement Process (SCIP) measure compliance regarding urinary device removal
- Reduce falls with serious injury to under the national benchmark for acute care hospitals
- Reduce number of pressure ulcer incidents

3A: What is the long-term improvement plan (next 2-4 years)?

- Continue to identify compliance/opportunities to reduce HAIs and HACs
- Continue monitoring compliance of DVT/PE prophylactics (prevention) protocols
- Increase patient and community involvement in overall patient safety initiatives
- Continue complying with National Patient Safety Goals (NPSG)

3B: How will the organization measure success?

- Compare reduction of HAIs and HACs over previous years
- Compare reduction of DVTs/PEs over previous years
- Utilize social media tools to inform and engage community on patient safety
- Maintain accreditations and licenses

4: Please give a statement of commitment:

The Valley Health System, of which Valley Hospital Medical Center is a part, is committed to providing safe, effective health care for all patients through a mix of hardwired processes, ongoing patient, staff and physician education and improved technology.

William Bee Ririe Hospital

address:
1500 Avenue H
Ely NV 89301

phone number:
775-289-3001

website:
wbrhely.org

accreditation:
The Joint Commission

bed count:
25

date of last inspection:
April 7, 2008

categories of services provided:

medical surgical obstetrical

services provided:

- anesthesia
- blood bank
- chemotherapy service
- CT scanner
- dietetic service
- emergency department (dedicated)
- ICU – medical/surgical
- laboratory – clinical
- magnetic resonance imaging
- neonatal surgery
- nuclear medicine services
- obstetric service
- operating rooms
- opthalmic surgery
- orthopedic surgery
- outpatient services
- pediatric services
- physical therapy services
- post-operative recovery rooms
- radiology services – diagnostic
- respiratory care services
- surgical services – inpatient
- surgical services – outpatient

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at William Bee Ririe Hospital, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	0 total inspections	
deficiency	**frequency**	**regulation**
total deficiencies for this facility	**0**	

how to read this table:

This table shows the number of complaints received against William Bee Ririe Hospital, including state or federal regulation status and whether they were substantiated.

COMPLAINTS (January 1, 2009 – December 31, 2009)	2 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	1	1	0
federal	0	0	0
total complaints for this facility	**1**	**1**	**0**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against William Bee Ririe Hospital, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	1 substantiated allegation	
allegation category	**sub-description**	**frequency**
resident/patient/client rights	failed to acquire informed consent	1
total substantiated allegations for this facility		**1**

William Bee Ririe Hospital's Response to the 2009 Annual Hospitals Report

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

Healthcare-acquired infections

2A: What is the short-term improvement plan (next 12 months)?

Decrease H.A.I.

2B: How will the organization measure success?

Through quality improvement.

3A: What is the long-term improvement plan (next 2-4 years)?

<no specific response>

3B: How will the organization measure success?

<no specific response>

4: Please give a statement of commitment:

W.B.R. CAH-RHC is committed to providing our patients with the safest, highest-quality, satisfying care possible. Adherence to quality and safety measures helps us build excellence into our mission.

Willow Springs Center

address:
690 Edison Wy
Reno NV 89502

phone number:
775-585-3303

website:
www.willowspringscenter.com

accreditation:
The Joint Commission
(under BHC West Hills Hospital)

bed count:
76

date of last inspection:
December 16, 2009

categories of services provided:

psychiatric

services provided:

- psychiatric – child/adolescent
- psychiatric – inpatient
- psychiatric – outpatient

how to read this table:

This table shows the number of inspections performed and the deficiencies cited at Willow Springs Center, including a title and frequency for each deficiency as well as the regulation cited.

INSPECTIONS (January 1, 2009 – December 31, 2009)	4 total inspections	
deficiency	**frequency**	**regulation**
nutritional status of patients	1	NAC 449.339
personnel policies	1	NAC 449.363
protection of patient	1	NAC 449.3628
total deficiencies for this facility	**3**	

how to read this table:

This table shows the number of complaints received against Willow Springs Center, including state or federal regulation status and whether they were substantiated.

COMPLAINTS (January 1, 2009 – December 31, 2009)	3 total complaints		
complaint	**substantiated**	**unsubstantiated**	**other**
state	2	1	0
federal	0	0	0
total complaints for this facility	**2**	**1**	**0**

how to read this table:

This table shows the number of substantiated allegations associated with complaints against Willow Springs Center, including an allegation category, sub-description, and frequency for each allegation.

SUBSTANTIANTED ALLEGATIONS (January 1, 2009 – December 31, 2009)	2 substantiated allegations	
allegation category	**sub-description**	**frequency**
accidents	protective supervision	1
resident/patient/client abuse	sexual	1
total substantiated allegations for this facility		**2**

Willow Springs Center's Response to the 2009 Annual Hospitals Report

1: Based on the findings for your hospital(s), identify priority areas for short-term and long-term improvement:

Willow Springs Center Patient Safety Plan defines a process through which we provide a safe and healthy environment in which hazards are eliminated and minimized for our patients, visitors, and staff. Our work-related injuries/illnesses are minimized through a program hazard reduction/elimination, i.e., personal protective equipment, education, and continuous monitoring for safety issues and concerns. Our Surveillance with Infection Prevention and Control focus on Hand Hygiene, Hospital-Acquired Infections and Risk for Suicide.

2A: What is the short-term improvement plan (next 12 months)?

Goal 7: NPSG.07.01.01: Reduce the risk of HAIs. According to CDC, each year, millions of people acquire an infection while receiving care, treatment or services in a health care organization. Consequently, HAIs are safety issues affecting all types of health care organizations.

Goal 15: NPSG.15.01.01: Identify individual at risk for suicide. Conduct a risk assessment that identifies specific characteristics of the patient served and environmental features that may increase or decrease the risk for suicide. Willow Springs Center addresses the immediate safety needs and most appropriate setting for treatment of the patient.

2B: How will the organization measure success?

<no specific response>

3A: What is the long-term improvement plan (next 2-4 years)?

Goal 7: NPSG.07.01.01: One of the most important ways to address HAIs is by improving the hand hygiene of health care staff. Compliance with CDC hand hygiene guidelines will reduce the transmission of infectious agents by staff to individuals served, thereby decreasing the incidence of HAIs.

Goal 15: NPSG.15.01.01: When a patient at risk for suicide leaves Willow Springs Center we provide suicide prevention information to the patient and the family, along with a discharge follow up phone call.

3B: How will the organization measure success?

Goal 7: NPSG.07.01.01: To ensure compliance with this National Patient Safety Goal, Willow Springs Center has assessed it compliance and with comprehensive hand hygiene programs which included hand hygiene policy and monitoring monthly and provide feedback of the compliances rate. Because of the ages of the patients that we serve, we also have special programs: Henry The Hand and The Bug Lady.

Goal 7: NPSG.07.01.01: To continue to identify patients at risk for suicide while they are under our care. Investigate all suicide gestures and provide feedback.

4: Please give a statement of commitment:

As Stated above Willow Springs Center Patient Safety Plan defines a process through which we provide a safe and healthy environment in which hazards are eliminated and minimized for our patients, visitors, and staff.

Our Purpose

SAFETY FIRST

KEEP ME SAFE and LISTEN TO ME!

APPENDICES

Appendix A

FACILITY INSPECTIONS

Severity & Scope

Criteria for Evaluation

2009

NEVADA STATE HEALTH DIVISION
Bureau of Health Care Quality & Compliance

SEVERITY & SCOPE MATRIX *Any Size Facility*	**SCOPE 1** ISOLATED *Involves 20% or < of residents*	**SCOPE 2** PATTERN *Involves > 20% to 50% of residents*	**SCOPE 3** WIDESPREAD *Involves > 50% of residents*
SEVERITY 4 SERIOUS HARM	Death or serious harm has occurred: serious harm includes, serious mental harm, impairment of bodily functions, dysfunction of any bodily organ or part, life-threatening harm or death; one or an isolated number of unrelated incidents **$1.000**	Death or serious harm has occurred: serious harm includes, serious mental harm, impairment of bodily functions, dysfunction of any bodily organ or part, life-threatening harm or death; a pattern of incidents **$1.000**	Death or serious harm has occurred: serious harm includes, serious mental harm, impairment of bodily functions, dysfunction of any bodily organ or part, life-threatening harm or death; a widespread number of incidents **$1.000**
SEVERITY 3 MINIMAL HARM	Minimal harm has occurred or is predictable: minimal harm includes, an impact on patient health, safety, rights or well-being; one or an isolated number of unrelated incidents **$400**	Minimal harm has occurred or is predictable: minimal harm includes, an impact on patient health, safety, rights or well-being; a pattern of incidents **$400**	Minimal harm has occurred or is predictable: minimal harm includes, an impact on patient health, safety, rights or well-being; a widespread number of incidents **$800**
SEVERITY 2 POTENTIAL HARM	Potential for harm: the health, safety, rights or well-being of a patient is indirectly threatened; one or an isolated number of unrelated incidents	Potential for harm: the health, safety, rights or well-being of a patient is indirectly threatened; a pattern of incidents	Potential for harm: the health, safety, rights or well-being of a patient is indirectly threatened; a widespread number of incidents **$200**
SEVERITY 1 MISSING DOCUMENTATION	Missing documents: no harm to patient is likely to occur; one or an isolated number of unrelated incidents	Missing documents: no harm to patient is likely to occur; a pattern of incidents	Missing documents: no harm to patient is likely to occur; a widespread number of incidents

*May impose partial ban for limited to persons needing care, treatment or services affected by the deficiency.

** May impose ban on admissions if the deficiencies directly affect the care, treatment or services furnished by residents.

HIGHLIGHTED AREAS INDICATE THAT A SANCTION MUST BE IMPOSED.

SEVERITY

CRITERIA FOR EVALUATION

NAC 449.99861 (NRS 449.037, 449.165)

Level 1	Deficiencies of severity level one concern requirements promulgated primarily for administrative purposes. No harm is likely to occur to a recipient. No negative recipient impact has occurred or is likely to occur. The ability of a recipient to achieve the highest practicable physical, mental or psychosocial well-being has not been and is not likely to be compromised.
Level 2	Deficiencies of severity level two indirectly threaten the health, safety, rights, security, welfare or well-being of a recipient. A potential for harm, as yet unrealized, exists. If continued over time, a negative impact on one or more recipients or a violation of one or more recipients' rights would occur or would be likely to occur or the ability of one or more recipients to achieve the highest practicable physical, mental or psychosocial well-being would be, or would likely be, compromised.
Level 3	Deficiencies of severity level three create a condition or incident in the operation or maintenance of a facility that directly or indirectly threatens the health, safety, rights, security, welfare or well-being of one or more recipients. A negative impact on the health, safety, rights, security, welfare or well-being of one or more recipients has occurred or can be predicted with substantial probability to occur or the ability of recipients to achieve the highest practicable physical, mental or psychosocial well-being has been or is about to be compromised and requires intervention and correction of the deficiency. Violation of a partial or complete ban on admissions imposed on a facility, violation of a limitation on occupancy of a residential facility or failure to implement a directed plan of correction is presumed to be a deficiency of this level of severity.
Level 4	Deficiencies of severity level four create a condition or incident that has resulted in or can be predicted with substantial probability to result in death or serious harm to a recipient. As used in this subsection, 'serious harm' includes serious mental harm, serious impairment of bodily functions, serious dysfunction of any bodily organ or part, life-threatening harm or death.

SCOPE

CRITERIA FOR EVALUATION

NAC 449.9986 (NRS 449.037, 449.165)

Level 1	A deficiency of scope level one consists of one or an isolated number of unrelated incidents in the sample surveyed. A deficiency is of this scope if it involves 20 percent or less of the recipients sampled in a facility.
Level 2	A deficiency is scope level two if the Bureau identifies a pattern of incidents at the facility, including any deficiencies involving recipients who require particular kinds of care, treatment or service. The number or percentage of recipients or staff involved in the incidents or the repeated occurrences of incidents in short succession may also establish a pattern by indicating a reasonable degree of predictability of similar incidents. A deficiency is also of this scope if it involves more than 20 percent but not more than 50 percent of the recipients sampled in a facility.
Level 3	A deficiency is of scope level three if it occurs in a sufficient number or percentage of recipients or staff or with sufficient regularity over time that it may be considered systemic or pervasive in or by the facility. A deficiency is also of this scope if it involves more than 50 percent of the recipients sampled in a facility.

INSPECTION PROCESS OVERVIEW

Every inspection conducted by BHCQC, includes evaluation of the facility for compliance with certain state and/or federal regulations and laws. In addition, procedures used by the facility are reviewed to determine whether the facility is providing health services in accordance with professional standards of practice. If one or more deficiencies are identified during an inspection, each deficiency is assigned a severity and scope score. Severities range from 1 to 4, with 4 being the worst possible outcome. The scopes range from 1 to 3, with 3 being the most widespread problem.

In addition to determining compliance with regulations, statutes, and standards of practice, in certain cases, inspectors also determine whether patients are in immediate jeopardy of serious harm. In cases where an immediate jeopardy has been determined, the inspectors remain on the premises until the situation is abated. During these situations, the inspector is in contact with a supervisor to determine the best course of action.

Following are two discussions of immediate jeopardy situations, to help illustrate the necessary actions:

1. While conducting a routine inspection of a dependent care facility, the inspector determines there is no caregiver on the premises. Residents at the facility have not received meals, medications, or supervision for approximately 8 hours. At least one resident is in need of immediate medical care. 9-1-1 is called to transport this resident to the hospital. However, the other residents are vulnerable and the situation is not yet abated. Unsuccessful attempts are made to contact the owner and administrator. Other agencies and services are contacted for assistance. Approximately 2 hours after the inspector's arrival, a caregiver arrives for her regularly scheduled shift at the facility. The inspector ascertains this caregiver is capable of providing adequate care to the remaining residents. The caregiver is able to contact the administrator of the facility. The administrator arrives at the facility and contacts other caregivers scheduled to work the next three full shifts. The administrator is instructed to generate a written plan to ensure caregiver coverage. The administrator complies and generates an acceptable plan. The immediate jeopardy situation is abated. Calls are made to all assisting agencies to inform them of the current status. The inspector may now exit the facility, however, follow up visits will be scheduled and an appropriate sanction[3] will be assigned for the deficiencies. Administrative sanctions may include fines and/or revocation of the facility license.

2. While conducting a complaint investigation concerning unsafe sterilization techniques at an ambulatory surgery center, an inspector identifies mechanical problems with the surgical instrument sterilizer. The inspector determines that the mechanical problems were previously unknown to the facility staff. The inspector determines that some surgeries are scheduled that will require the use of the instruments previously processed in this sterilizer. The inspector immediately advises the facility to postpone the surgeries until a solution can be implemented. The facility staff are cooperative and begin rescheduling surgeries. The inspector determines that not all surgeries require instruments previously processed in the dysfunctional sterilizer; some procedures are performed with single use instruments. The inspector informs the facility that they may only continue procedures wherein the instruments to be used are for single use and were not processed in the sterilizer. The inspector informs the facility that they must develop a written plan to identify and re-sterilize instruments that had potentially not been properly sterilized. The facility cooperates, and provides an acceptable plan. The immediate jeopardy situation is abated. The inspector may now exit the facility, however, follow up visits will be scheduled and an appropriate sanction will be assigned for the

[3] NAC 449.0066 "Sanction" defined. "Sanction" means a corrective measure or penalty that is imposed by the Bureau upon a facility.

deficiencies. Administrative sanctions may include fines and/or an order to cease procedures that would require the use of surgical instruments that require sterilization until the sterilizer is repaired or replaced.

ADMINISTRATIVE SANCTIONS

Administrative sanctions are assigned to encourage facilities to comply with requirements and to protect and inform Nevada's healthcare recipients about substandard quality healthcare. A full range of sanctions is available, and the administrative code defines how each sanction must be applied.

Following is a list of available sanctions:

- Require a plan of correction or directed plan of correction
- Monitor the facility
- Limit occupancy
- Ban admissions
- Impose monetary penalties
- Assume temporary management
- Suspend or revoke the facility's license
- Close the facility

Sanctions must be applied in accordance with the rules established in the administrative code. Sanctions are selected from the list based on what NSHD deems most likely to correct the deficiencies. Absent evidence to the contrary, restrictions on service and monetary penalties are presumed to be the most effective sanctions for deficiencies that do not cause an immediate and serious threat to healthcare recipients. Sanctions are imposed in a manner that allows for escalation, if deficiencies are not corrected.

For example, an inspection reveals that a facility has deficiencies at severity 2 and scope 3. In this case, BHCQC doesn't initially contemplate revocation of the license, but instead requires an acceptable plan of correction. If the deficiencies continue, then BHCQC may consider one time monetary penalties. If deficiencies persist beyond the monetary penalty, then BHCQC may consider daily fines or eventually revoke the license.

Except in emergency situations, facilities must be given written notice concerning sanctions and must be afforded the right of appeal in accordance with NAC chapter 439.

MONETARY PENALTIES

Monetary penalties are based on the severity and scope scores assigned to deficiencies. Monetary penalties start at $200 for deficiencies at severity 2 and scope 3 and increase to $1,000 per deficiency at severity level 4. Daily fines can also be assessed at $10 per patient per day for each day that a deficiency continues. Fines can also be increased for repeat deficiencies or if compliance is falsely alleged. Monetary penalties have been inserted into the severity and scope grid.

BAN ON ADMISSIONS

A ban on admissions or partial ban on admissions is based on the severity and scope scores assigned to the deficiencies. A ban on admissions is used to prevent the admission of persons who cannot be adequately served by the facility. If the deficiency is related to a discrete type of care, treatment or services, a partial ban on admissions may be used to order a facility to cease performing a particular procedure. Partial bans limit new admissions to those not requiring care, treatment or services for which the deficiency is found. Ban on admissions and partial ban on admissions have been inserted into the severity and scope grid on the previous pages to illustrate.

SANCTION IMPOSITION

At least one sanction must be imposed for each deficiency in a facility with a severity 4 and for each deficiency in a facility with a combined severity and scope score of 6 or more (letter 'I' or above in the grid). BHCQC may impose sanctions for deficiencies of a severity 3 or less or where a combined severity and scope score of less than 6 is identified. More than one sanction may be imposed in the discretion of BHCQC.

For example, a facility has a deficiency at severity 4 and scope 2. BHCQC may impose both a complete ban on admissions and a monetary penalty of $1,000.

SUMMARY SUSPENSION/REVOCATION

In emergency situations where an immediate jeopardy situation is not abated, BHCQC may impose summary suspension of a license, and transfer patients/residents to a safe setting prior to revocation proceedings. This sanction is only applicable after efforts to abate an immediate jeopardy situation have failed.

CEASE OPERATION

If a facility does not respond to a revocation notice or when a facility does not appeal a revocation, BHCQC may issue a notice to cease operation. These notices are also used for unlicensed facilities that begin operation without first applying for a license from BHCQC.

FACILITY CLOSURE

If lesser sanctions do not prompt a facility to correct its deficiencies or if it is determined that a healthcare provider may be continuing practices that jeopardize patients or a facility's ability to safely deliver healthcare is so diminished that patients are in jeopardy, then an order for facility closure may be necessary to ensure the protection of public health and healthcare recipients. This sanction is only considered when other efforts to protect the public health have failed.

Appendix B

DEFICIENCIES CITED IN 2009

deficiency tag	regulation
adequate respiratory care staffing	482.57(a)(2)
administration of drugs	482.23(c)
administration of medication	NAC 449.344
admission of patients	NAC 449.329
appropriate care of patient	NAC 449.3622
assessment of patient	NAC 449.3624
assessment of patients	NAC 449.3624
blood gases/lab test requirements	482.57(b)(2)
blood transfusions	NAC 449.3735
chief executive officer	482.12(b)
compliance with 489.24	489.20(l)
compliance with construction standards	NAC 449.3156
confidentiality of medical records	482.24(b)(3)
construction standards	NAC 449.3154
content of record – informed consent	482.24(c)(2)(v)
delivery rooms	NAC 449.3645
dietary services	NAC 449.338
direct services	485.635(b)(2)
direct services	485.635(b)(3)
director of dietary services	482.28(a)(1)
director of respiratory services	482.57(a)(1)
discharge planning	NAC 449.332
discharge planning needs assessment	482.43(b)(1)
emergency laboratory services	482.27(a)(1)
emergency preparedness	NAC 449.316
emergency services	482.55
emergency services	NAC 449.331
emergency services	NAC 449.349
governing body	482.12
governing body	NAC 449.313
housekeeping services	NAC 449.322
infection control officer responsibilities	482.42(a)(1)
infection control officer(s)	482.42(a)
infections and communicable diseases	NAC 449.325

Table 12

DEFICIENCIES CITED IN 2009

deficiency tag	regulation
intensive care services	NAC 449.371
life safety code standard	NFPA 101
maintenance	485.623(b)(4)
maintenance of physical plant	482.41(a)
medical record services	482.24
medical records	NAC 449.379
medical screening exam	489.24(r) & 489.24(c)
medical staff	482.62(b)(2)
medical staff	NAC 449.358
medical staff – accountability	482.12(a)(5)
medical staff responsibilities	482.22(c)(5)
medication orders	NAC 449.343
nursing care plan	482.23(b)(4)
nursing service	NAC 449.361
nursing services	482.23
nursing services	482.62(d)(1)
nursing services	482.62(d)(2)
nursing services	485.635(d)
nursing services	485.635(d)(3)
nursing services	485.635(d)(4)
nursing services	NAC 449.361
nutritional status of patients	NAC 449.339
obstetrical services	NAC 449.364
on call physicians	489.20(r)(2) & 489.24(j)(1-2)
operating budget	NAC 449.313
operating room policies	482.51(b)
outpatient services	NAC 449.370
patient care policies	485.635(a)(3)(iv)
patient care policies	485.635(a)(3)(vi)
patient care policies	485.635(a)(3)(vii)
patient care policies	485.635(a)(4)
patient rights	482.13
patient rights: admission status notification	482.13(b)(4)
patient rights: care in safe setting	482.13(c)(2)

DEFICIENCIES CITED IN 2009

deficiency tag	regulation
patient rights: confidentiality of records	482.13(d)
patient rights: free from abuse/harassment	482.13(c)(3)
patient rights: grievance procedures	482.13(a)(2)(i)
patient rights: grievance review time frames	482.13(a)(2)(ii)
patient rights: grievances	482.13(a)(2)
patient rights: informed consent	482.13(b)(2)
patient rights: notice of grievance decision	482.13(a)(2)(iii)
patient rights: restraint or seclusion	482.13(e)(10)
patient rights: restraint or seclusion	482.13(e)(11)
patient rights: restraint or seclusion	482.13(e)(2)
patient rights: restraint or seclusion	482.13(e)(3)
patient rights: restraint or seclusion	482.13(e)(4)(i)
patient rights: restraint or seclusion	482.13(e)(4)(ii)
patient rights: restraint or seclusion	482.13(e)(5)
patient rights: restraint or seclusion	482.13(f)
patient rights: review of grievances	482.13(a)(2)
patient rights: timely referral of grievances	482.13(a)(2)
personnel policies	NAC 449.363
pharmaceutical services	NAC 449.340
pharmacist responsibilities	482.25(a)(1)
physical environment	482.41
physical environment	NAC 449.316
physical restraint use	NAC 449.3628
policies for laboratory services	482.27(a)(4)
potentially infectious blood/blood products	482.27(b)
protection of patient	NAC 449.3628
protection of patients	NAC 449.3628
provision of services	485.635
psychiatric services	NAC 449.394
QAPI	482.21
QAPI feedback and learning	482.21(c)(2)
QAPI improvement activities	482.21(c)(2)
QAPI program scope	482.21(a)
qualified dietitian	482.28(a)(2)

DEFICIENCIES CITED IN 2009

deficiency tag	regulation
qualified emergency services personnel	482.55(b)(2)
qualified staff	482.26(c)(2)
quality improvement	NAC 449.3152
quality improvement program	NAC 449.3152
quality of care	NAC 449.314
quality of care/policies procedures	NAC 449.314
quality of care/staffing	NAC 449.314
radiologist responsibilities	482.26(c)(1)
records systems	485.638(a)(4)(i)
records systems	485.638(a)(4)(ii)
rehabilitative services	NAC 449.346
respiratory care services	NAC 449.389
respiratory care services policies	482.57(b)
rights of patient	NAC 449.3626
RN supervision of nursing care	482.23(b)(3)
sanitary conditions – supplies for food	NAC 449.3395
sanitary conditions and supplies for food	NAC 449.3395
social services	NAC 449.352
specific medical record requested for psychiatric hospitals	482.61
staff education	482.45(a)(5)
staffing and delivery of care	482.23(b)
sterile supplies and medical equipment	NAC 449.327
supervision of contract staff	482.23(b)(6)
surgical services	NAC 449.385
tissue and eye bank agreements	482.45(a)(2)
transfer agreements	NAC 449.331
treatment plan	482.61(c)(1)
treatment plan	482.61(c)(1)(ii)
treatment plan	482.61(c)(1)(iii)
treatment plan	482.61(c)(1)(iv)
treatment plan	482.61(c)(2)
unusable drugs not used	482.25(b)(3)
use of restraint or seclusion	482.13(e)
written protocol for tissue specimens	482.27(a)(3)

Appendix C

URBAN HOSPITALS LICENSED IN 2009

	medical	surgical	obstetrical	psychiatric
BHC West Hills Hospital				✓
Carson Tahoe Regional Medical Center	✓	✓	✓	✓
Centennial Hills Hospital Medical Center	✓	✓	✓	
ContinueCARE Hospital of Carson Tahoe	✓			
Desert Canyon Rehabilitation Hospital	✓			
Desert Springs Hospital Medical Center	✓	✓		
Desert Willow Treatment Center				✓
Dini-Townsend Hospital at Northern Nevada Adult Mental Health Services				✓
Harmon Medical and Rehabilitation Hospital	✓			
HealthSouth Hospital at Tenaya	✓			
HealthSouth Rehabilitation Hospital of Henderson	✓			
HealthSouth Rehabilitation Hospital of Las Vegas	✓			
Horizon Specialty Hospital – Las Vegas	✓			
Kindred Hospital – Las Vegas (Flamingo Campus)	✓			
Kindred Hospital – Las Vegas (Sahara Campus)	✓			
Kindred Hospital – Las Vegas at Desert Springs Hospital	✓			
Lake's Crossing Center				✓
Montevista Hospital				✓
MountainView Hospital	✓	✓	✓	
North Vista Hospital	✓	✓	✓	✓
Northern Nevada Medical Center	✓	✓		✓
Progressive Hospital	✓			

Table 13

URBAN HOSPITALS LICENSED IN 2009

	medical	surgical	obstetrical	psychiatric
Red Rock Behavioral Hospital				✓
Renown Regional Medical Center	✓	✓	✓	
Renown Rehabilitation Hospital	✓			
Renown South Meadows Medical Center	✓	✓		
Saint Mary's Regional Medical Center	✓	✓	✓	
Seven Hills Behavioral Institute				✓
Sierra Surgery Hospital		✓		
Southern Hills Hospital and Medical Center	✓	✓	✓	
Southern Nevada Adult Mental Health Services				✓
Spring Mountain Sahara				✓
Spring Mountain Treatment Center				✓
Spring Valley Hospital Medical Center	✓	✓	✓	
St. Rose Dominican Hospitals – Rose de Lima Campus	✓	✓	✓	
St. Rose Dominican Hospitals – San Martin Campus	✓	✓	✓	
St. Rose Dominican Hospitals – Siena Campus	✓	✓	✓	
Summerlin Hospital Medical Center	✓	✓	✓	
Sunrise Hospital and Medical Center	✓	✓	✓	
Tahoe Pacific Hospital – Meadows	✓	✓		
Tahoe Pacific Hospitals – West	✓	✓		
University Medical Center of Southern Nevada	✓	✓	✓	
University Medical Center Rancho Rehabilitation Center	✓			
Valley Hospital Medical Center	✓	✓	✓	
Willow Springs Center				✓

Appendix D

RURAL HOSPITALS LICENSED IN 2009

	medical	surgical	obstetrical	psychiatric
Banner Churchill Community Hospital	✓	✓	✓	
Battle Mountain General Hospital	✓			
Boulder City Hospital	✓	✓		
Carson Valley Medical Center	✓	✓		
Desert View Regional Medical Center	✓	✓		
Grover C Dils Medical Center	✓			
Humboldt General Hospital	✓	✓	✓	
Incline Village Community Hospital	✓	✓		
Mesa View Regional Hospital	✓	✓	✓	
Mount Grant General Hospital	✓	✓		
Northeastern Nevada Regional Hospital	✓	✓	✓	
Nye Regional Medical Center	✓	✓		
Pershing General Hospital	✓	✓		
South Lyon Medical Center	✓	✓		
William Bee Ririe Hospital	✓	✓	✓	

Table 14

FEEDBACK AND INFORMATION REQUESTS

Please submit the completed form by mail, fax, or email to:

Nevada State Health Division
4150 Technology Wy Carson City NV 89706
email: mframsted@health.nv.gov
fax: (775) 684-4156

1. How did you come across this report?

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2. Please rate the overall value of the report.

no value	little value	indifferent/ no opinion	valuable	very valuable
☐	☐	☐	☐	☐

3. comments

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